

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12284

CERTIFICATE OF DEATH

Reg. Dist. No. 242

12197

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince George		MARYLAND		STATE Maryland COUNTY Prince George			
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Southlawn		LENGTH OF STAY (in this place) 7 Mon.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Southlawn X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6504-Leyte Drive				STREET ADDRESS (If rural give location) 6504-Leyte Drive			
3. NAME OF DECEASED: (First) (Middle) (Last) MICHAEL EDWARD ACTON				4. DATE (Month) (Day) (Year) OF DEATH: Dec. 27 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: May, 24-1955	9. AGE last birthday 7-Mon.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: Mercer Sinclair Acton				14. MOTHER'S MAIDEN NAME: Phyllis Pillsbury			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: None		17. INFORMANT & ADDRESS: Mercer S. Acton (Father)			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 571-0 (A) Acute cardiac arrest						Sudden	
ANTECEDENT CAUSE (S) (B) Undetermined						—	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Infectious diarrhea						3 days.	
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION —				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 22, 1955 to Dec 27, 1955 that I last saw the deceased alive on Dec 26, 1955 , and that death occurred at 4:30 AM , from the causes and on the date stated above. SIGNATURE Leo H. Mugmon ADDRESS M. D. 2711 Gaither St. P.G. Co. DATE SIGNED Dec 28, 1955							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-30-55		NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR Dec 29-55		REGISTRAR'S SIGNATURE Carrie Campbell		24. FUNERAL DIRECTOR W.W. Chambers Co.		ADDRESS 517 11th St. S.E. D.C.	
W.W. Chambers Co. 517-11st. S.E.							

RECEIVED

JAN 5 1956

BUREAU V. S.

12222

CERTIFICATE OF DEATH

12198

Reg. Dist. No. 231

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY PRINCE GEORGES		STATE MARYLAND		STATE D. C.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CHEVERLY		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2601 Cheverly Avenue				STREET ADDRESS 2916 7th. St. N.E.			
3. NAME OF DECEASED (Type or Print) WILLIAM H. ALDRICH				4. DATE OF DEATH 18 - 18 19 55			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 1-19-75	
9. AGE last birthday 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Aldrich				14. MOTHER'S MAIDEN NAME Abigail Gale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mary A. Aldrich 2916 7th. St. N.E. Wash. D. C.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A) Cerebral Vascular Occlusion				INTERVAL BETWEEN ONSET AND DEATH 12/7/55			
ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arterio Sclerosis				years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Parkinsonian Syndrome secondary to Arterio Sclerosis				years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/7/55, 19 to 12/17/55, 19, that I last saw the deceased alive on 12/17/55, 19, and that death occurred at 2 PM M, from the causes and on the date stated above.							
SIGNATURE John J. Sweeney M.D.				DATE SIGNED 12/18/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-21-55		NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		LOCATION (City, town, or county) (State) ARLINGTON, VA.	
24. REC'D BY REGISTRAR DATE 12/21/55		REGISTRAR'S SIGNATURE Amanda Downey		25. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS 3821 14th. St. N.W. Washington, D. C.	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Usual Residence (Name & Address)

2. Date of Death

3. Place of Death

4. Cause of Death

5. Duration of Illness

6. Name of Physician

7. Name of Hospital

8. Age

9. Sex

10. Race

11. Marital Status

12. Name of Informant

13. Signature of Informant

14. Name of Registrar

15. Signature of Registrar

BUREAU V. S.

DEC 27 1933

RECEIVED

SMITHSONIAN INSTITUTION

RECEIVED
 NATIONAL MUSEUM
 DEPARTMENT OF AGRICULTURE
 WASHINGTON, D. C.
 JAN 1 1934

12223

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges MARYLAND				STATE Md. COUNTY Pr. Geo. City.			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 381 Cherry, Md.				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cottage City, Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 777 A. Geo. Gen. Hosp.				STREET ADDRESS (If rural give location) 3710-41st Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Mabel S Auguste				Dec. 22 1955			
5. SEX: F.		6. COLOR OR RACE: W.		7. SINGLE. MARRIED. WIDOWED. DIVORCED. M.		8. DATE OF BIRTH: 4-20-02	
				9. AGE last birthday 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bank Sells.				10B. KIND OF BUSINESS OR INDUSTRY: Bank.			
11. BIRTHPLACE (State or foreign country): Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME: Charles Garretson				14. MOTHER'S MAIDEN NAME: Lucy Beatty			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Gen.			
17. INFORMANT & ADDRESS: Mr. John L. Auguste, 3710 41st av, Cottage City, Md.							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 199.9 Lymphoid Carcinoma of ax 55							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 1 Oct. 16 1955				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 3, 1955, to Dec 22, 1955, that I last saw the deceased alive on 12-22, 1955, and that death occurred at 11 A. M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
George H. George		M. D. 3717-38th Ave Cottage City, Md.		12-22-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
Buried		12-27-1955		St. Lincoln Cem		Bladensburg, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
12/24/55		Amelia L. Dorney		W. W. Chambers Co. Wash. D.C.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 28 1955

RECEIVED

12220 CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE Maryland		COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
16 TOWN Mt. Rainier				16 TOWN Mt. Rainier			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3332-Buchanan st.				STREET ADDRESS (If rural give location) 3332-Buchanan street			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
OF DEATH: (Type or Print) Harry B. Bachrach				OF DEATH: 12-9-55 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	married	April 11, 1888	67 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Retired Lawyer		Legal		Grodno, Russia		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
David Bachrach				Altar Katner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						Ada Martini Bachrach wife 3332-Buchanan st. Mt. Rainier, Md.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
155X IMMEDIATE CAUSE				(A) Generalized / Hepatic Coma		2 day	
ANTECEDENT CAUSE (S)				(B) Generalized Carcinomatosis		6 mo	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) 1° Carcinoma Gall Bladder		6 mo +	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic H. D.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
11-8-55		1° Carcinoma Gall Bladder					
20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 15, 1955, to Dec 7, 1955, that I last saw the deceased alive on Dec 8, 1955, and that death occurred at 7 P. M., from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Francis D. Fowler		M. D. 1840 Mich Ave		Dec 7-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12/12/55		Arlington National Cem.		Arlington, Va	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
12-11-1955		Mrs. Jas. Beres		Halleys Funeral Home, Inc.		3200 - R. I. Ave. Mt. Rainier Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 13 1955

RECEIVED

12224

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>PRINCE GEORGE</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
38 TOWN <u>Cherely M.D.</u>				OR TOWN <u>East Riverdale Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PRINCE GEORGE CO. HOSP.</u>				STREET ADDRESS (If rural give location) <u>5305 59th Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Edward William BAUER</u>				OF DEATH <u>DECEMBER 25</u> 19 <u>55</u>			
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Widowed</u>	8. DATE OF BIRTH: <u>July 21 1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Boiler Maker</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>✓</u>	11. BIRTHPLACE (State or foreign country): <u>PENN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>August Bauer</u>				14. MOTHER'S MAIDEN NAME: <u>unborn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>201-14-9850</u>		17. INFORMANT & ADDRESS: <u>Mrs. Helen S. Hauerwald 5305 59th Av. East Riverdale, Md.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>1 day</u>	
DUE TO							
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerotic Heart Disease</u>						<u>10 years</u>	
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Prostateism</u>							
19A. DATE OF OPERATION: <u>0</u>			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>55</u> , to <u>24 Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>24 Dec</u> , 19 <u>55</u> , and that death occurred at <u>9:50</u> A M, from the causes and on the date stated above.							
SIGNATURE <u>Leon R. Gallin</u>			ADDRESS <u>Mt. Airview Md</u>			DATE SIGNED <u>12/25/55</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>12-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/29/55</u>		REGISTRAR'S SIGNATURE <u>Virginia Downey</u>		24. FUNERAL DIRECTOR <u>W.W. Chambers Co</u>		ADDRESS <u>Riverdale, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

DEC 29 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12225

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12203
Reg. Dist. No. 245

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE Va.		COUNTY Augusta	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Riverdale				CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Middlebrook			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Leland Memorial Hosp.				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED:		(First) William		(Middle) Carlyle		(Last) Beard	
(Type or Print)							
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: 5/14/20	
						9. AGE last birthday: 35 yrs.	
						10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farmer	
						11. BIRTHPLACE (State or foreign country): Va.	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: William E. Beard				14. MOTHER'S MAIDEN NAME: Bulah East			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: Unk.		17. INFORMANT & ADDRESS: 5114 U St., S. E. Louis B. Clark Washington 27 Brotherinlaw	

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause		(a) Hemorrhage & shock -					
Antecedent cause(s)		DUE TO Laceration of R. lung and liver -					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		DUE TO					
		(c)					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 12-2-55 8:10 A.M.				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Struck by R.R. Train	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED					
John W. Maloney (Hyattsville, Md.)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. 12-2-55					
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 12/4/55		NAME OF CEMETERY OR CREMATORY New Prov. Church Cemetery		LOCATION (City, town, or county) (State) Raphine Rockbridge Va.	
DATE REC'D BY LOCAL REG. 12/2/55		REGISTRAR'S SIGNATURE Mrs. Jas. - Devereux		24. FUNERAL DIRECTOR		ADDRESS 1661 - Ford Ave N.E. Washington D.C.	

RECEIVED

DEC 6 1955

BUREAU V. S.

12211

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE		COUNTY 47X-3	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
15 TOWN Hyattsville		2 mos.		WASHINGTON D.C.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
08				4860 Fort Totten Dr. NE			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)			
GERTRUDE		EDNA		BOSS			
(Type or Print)				OF DEATH: Dec 1		19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Fe.	Wh.	MARRIED	21 Aug 1891	64 yrs.	3 Months	9 Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Homemaker						Washington, D.C.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Samuel H. Sherwood				Mary E. Doyle			
15. Was DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
HNO						Husband Robert L. Boss. 4860 Ft. Totten Dr. NE Wash. D.C.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
150X IMMEDIATE CAUSE (A) Careinomatosis		6 mos.
ANTECEDENT CAUSE (S) DUE TO (B) Carcinoma of esophagus.		about 14 mos
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
18 Oct 54		Carcinoma of esophagus.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory) OF INJURY street/office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Aug, 1955, to 1 Dec, 1955, that I last saw the deceased alive on 30 Nov, 1955, and that death occurred at 6:10 A M, from the causes and on the date stated above.

SIGNATURE Charles E. Keegan Jr. ADDRESS M.D. 1617 35th St. NW Wash. D.C. DATE SIGNED 1 Dec 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
		Dec. 5, 1955	Fort Lincoln Cem.	Colman Manor Md.
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
Dec. 1 1955		Mrs. Jas. Senese	J. Wm. Lewis Co. Inc. 300 - 14th St. NE Wash. D.C.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 5 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 245

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Prince George's MARYLAND		STATE Maryland COUNTY Prince George's	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR	
TOWN Laural	4 1/2 months	TOWN Forestville X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Laural Sanitorium		STREET ADDRESS (If rural, give location) 8200 Marlboro Pike /	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
(Type or Print) Jane Sparrow Boyd		12 18 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Female	White	W	August 13, 1870
9. AGE last birthday: 85 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None		10b. KIND OF BUSINESS OR INDUSTRY:	
		Union Hill, New Jersey	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
U.S.A.			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
John Sparrow		Ellen Barden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
No		None	
17. INFORMANT & ADDRESS:			
Dr. James I. Boyd, Forestville, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES AND CONDITIONS DIRECTLY LEADING TO DEATH: <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Immediate cause</p> <p>Antecedent cause(s)</p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</p> </div> <div style="width: 50%;"> <p>(a) <u>Cerebro-vascular accident, fractured left hip.</u></p> <p>DUE TO</p> <p>(b) <u>Cardiovascular renal disease.</u></p> <p>DUE TO</p> <p>(c)</p> </div> </div>		INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Sanitorium</u>	21c. (City or town) (County) (State) <u>Laurel Prince George's Md.</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12-17-55 6 A.M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fell to the floor.</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>		
SIGNATURE <u>John J. Maloney (Hyattsville, Md.)</u>	CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>translocation</u>	DATE THEREOF <u>12/21/55</u>	NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>
DATE REC'D BY LOCAL REG. <u>Dec. 19, 1955</u>	REGISTERAR'S SIGNATURE <u>James Devey</u>	24. FUNERAL DIRECTOR <u>J. Gasek sons, Hyattsville, Md.</u>
		LOCATION (City, town, or county) (State) <u>Brooklyn N.Y.</u>
		DATE SIGNED <u>12-18-55</u>

RECEIVED

DEC 28 1855

BUREAU V. S.

12227

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince Georges</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		16	
TOWN <i>Cheverly</i>				TOWN <i>Mount Ranier</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Prince Georges Geriatrics</i>				STREET ADDRESS (If rural give location) <i>4000-33rd Street</i>			
3. NAME OF DECEASED: (First) <i>Hazel</i> (Middle) (Last) <i>Boyle</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>12-21-1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH: <i>8-4-99</i>	
9. AGE last birthday <i>56</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		IF UNDER 24 HRS.	
		Months		Days		Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>Own Home</i>			
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME: <i>James Moberg</i>				14. MOTHER'S MAIDEN NAME: <i>Emma Burton</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT & ADDRESS: <i>Statistic Card</i>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
581.0 IMMEDIATE CAUSE				(A) <i>Bronchopneumonia</i>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.				(B) <i>Cirrhosis of Liver</i>			
				DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Pneumococcal Bacteremia</i>							
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION			
				20. AUTOPSY: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June</i> , 19 <i>55</i> to <i>12/21</i> , 19 <i>55</i> that I last saw the deceased alive on <i>12/21</i> , 19 <i>55</i> , and that death occurred at <i>9:00</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>Norman D. MacLean M.D.</i>				ADDRESS <i>3503 Perry St. Mt. Rainier Md.</i>			
DATE SIGNED <i>12/21/55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>Dec. 24, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>	
						LOCATION (City, town, or county) (State) <i>Colmar Manor Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>12/24/55</i>				REGISTRAR'S SIGNATURE <i>Amanda Downey</i>		24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>	
						ADDRESS <i>Hyattsville, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1955

BUREAU V. S.

12228

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges'</u> MARYLAND		STATE <u>—</u> COUNTY <u>—</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>		LENGTH OF STAY (in this place) <u>9 1/2 hrs.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cheverly</u>		STREET ADDRESS (If rural give location) <u>514 - 104th St. S.E.</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges' Gen. Hosp.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Georgina Alice Burns</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>Dec 11 1953</u>			
5. SEX: <u>FEMALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>8-15-01</u>	
9. AGE last birthday <u>54</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>		11. BIRTHPLACE (State or foreign country): <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George Saloan</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Christa</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>—</u>		17. INFORMANT & ADDRESS: <u>Statistic Card</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>443X</u>							
ANTECEDENT CAUSE (S) <u>Inten-Cerebral Hemorrhage</u>						<u>7 hrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>HYPERTENSIVE Cardio VASCULAR</u>							
(C) <u>Disease</u>						<u>5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/10, 1953</u> , to <u>12/10, 1953</u> , that I last saw the deceased alive on <u>12/10, 1953</u> , and that death occurred at <u>12:18 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>William D. D. D.</u>		ADDRESS <u>M.D. 3503 Rm. 11. 211 Rm. 11</u>		DATE SIGNED <u>12/10/53</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>13 Dec 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Colmar Manor Pr. Geo. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/12/55</u>		REGISTRAR'S SIGNATURE <u>Amanda Doney</u>		24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

DEC 16 1955

BUREAU

Dr. W. H. S.

Dr. W. H. S. notified. Not a learner
case.

Mr. C. W. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12208

12285 CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince George</u>		STATE <u>MARYLAND</u>		STATE <u>Virginia</u> COUNTY <u>Fairfax</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Beltsville</u>				TOWN <u>Sterling</u>		<u>83X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4504 Tonquil St</u>				STREET ADDRESS (If rural give location) <u>R.F.D.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Enna H Burr</u>				<u>Dec 2 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Nov. 7 1874</u>	<u>81</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Farming</u>		<u>Virginia</u>			
13. FATHER'S NAME <u>Charles Burr</u>				14. MOTHER'S MAIDEN NAME <u>Annie Kaylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mrs Lovenia G Burr</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
151X IMMEDIATE CAUSE (A) <u>Metastatic Carcinoma</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of Stomach</u>				<u>18 Mo.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>11/7/54</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Stomach</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 54</u> , to <u>Dec 2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 3</u> , 19 <u>55</u> , and that death occurred at <u>8:45A</u> , from the causes and on the date stated above. <u>12/3/55</u>							
SIGNATURE <u>Harold Hanger</u>				ADDRESS (Street, city, town, state) <u>M.D. 1835 Eyett NW Wash DC</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 4, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove Cem</u>		LOCATION (City, town, or county) (State) <u>Herndon Va</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John D. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Pearson's Funeral Home</u>		ADDRESS <u>Gallo Church - Va</u>	
DATE <u>Dec 7-1955</u>							

1922 CERTIFICATE OF DEATH

ATTEST: REGISTERED DEPARTMENT OF HEALTH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF DEATH

11. MEDICAL CERTIFICATION

12. SIGNATURE OF PHYSICIAN

BUREAU V. S.

DEC 9 1922

RECEIVED

REGISTRATION

12209

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Prince George's	MARYLAND	STATE Maryland	COUNTY Prince George's
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
14 TOWN College Park, Md.	7 years	OR TOWN College Park, Md. 14	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4504 Albion Road		STREET ADDRESS (If rural give location) 4504 Albion Rd.	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
Joseph F. Butler		OF DEATH: December 1, 19 55.	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) widowed	8. DATE OF BIRTH: Aug 10, 1869
9. AGE last birthday 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Shoemaker		10B. KIND OF BUSINESS OR INDUSTRY: own business	
11. BIRTHPLACE (State or foreign country): Canada		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME: Unknown		14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 4 (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: Mrs Dorothy Hunt College Park, Md.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
443X IMMEDIATE CAUSE (A) UREMIC COMA			10 MIN
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			2 MOS
(B) CONGESTIVE HEART FAILURE			
(C) Arteriosclerotic Hypertensive Heart Disease			6 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 29, 19 54, to Dec. 1, 19 55, that I last saw the deceased alive on Dec. 1, 19 55, and that death occurred at 8 P M, from the causes and on the date stated above.			
SIGNATURE David A. Clayman		DATE SIGNED Dec. 2, 19 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/6/55	
NAME OF CEMETERY OR CREMATORY Calvary Cemetery		LOCATION (City, town, or county) (State) Brockton Mass.	
DATE REC'D BY LOCAL REGISTRAR Dec. 3, 19 55		24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 8 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12210
Item 13, Film G190 12-9-55 et
12286 CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>PRINCE GEORGES</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BELTSVILLE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4500 AMMENDALE ROAD.</u>			STATE <u>MARYLAND</u> COUNTY <u>PRINCE GEORGES</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BELTSVILLE</u> STREET ADDRESS (If rural give location) <u>4500 AMMENDALE ROAD.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>MARTHA ANN CAMPBELL</u>			4. DATE OF DEATH: (Month) (Day) (Year) <u>12 - 3 1955</u>		
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>MARCH 11, 1870</u>		9. AGE last birthday: <u>85</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country): <u>COM BER ONTARIO, CANADA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME: <u>Unknown</u>		
14. MOTHER'S MAIDEN NAME: <u>NANCY VLCH</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		
16. SOCIAL SECURITY NO.: <u>NONE</u>			17. INFORMANT & ADDRESS: <u>MR. RUSSELL U. MAC DUFF BELTSVILLE, MD. 4500 AMMENDALE R.D.</u>		

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>592X</u> Immediate cause (a) <u>Uremia</u> Antecedent causes (s) (b) <u>Congestive Heart Failure</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Chronic Nephritis</u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>					
19a. DATE OF OPERATION: <u>None</u>		19b. MAJOR FINDINGS OF OPERATION: <u>None</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		PLACE (Home, farm, factory, street, or office, etc.) <u>None</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>None</u>	
22. I hereby certify that I attended the deceased from <u>12/3</u> , 19 <u>55</u> , to <u>12/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/3</u> , 19 <u>55</u> , and that death occurred at <u>9:20 PM</u> , from the causes and on the date stated above. SIGNATURE (Degree or title) <u>R. E. Erickson M.D.</u> ADDRESS <u>Laurel, Maryland</u> DATE SIGNED <u>12/3/55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>12/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATIONAL</u> LOCATION (City, town, or county) (State) <u>SUITLAND, P.G. COUNTY, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>December 5, 1955</u>		REGISTRAR'S SIGNATURE <u>John D. Smith</u>		24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO.</u> ADDRESS <u>RIVERDALE MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 6 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12229
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12211
Reg. Dist. 23
No. 147

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write OR and give nearest town) TOWN <u>Chesley</u>		LENGTH OF STAY (in this place) <u>20.00</u>		CITY (If outside corporate limits write OR and give nearest town) TOWN <u>Cohran Manor</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Sin Hosp</u>				STREET ADDRESS (If rural, give location) <u>3605-40th Ave</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Jamice</u>		(Middle) <u>Lee</u>		(Last) <u>Carnes</u>		(Month) (Day) (Year) <u>12-27 1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, (DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH:	
						9. AGE last birthday: <u>31</u> yrs. <u>31</u> Months <u>31</u> Days <u>31</u> Hours <u>31</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore Maryland</u>	
13. FATHER'S NAME: <u>Samuel Webster Carnes</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Jane Caprio</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>9</u>				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mother - Same address</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<p>491X</p> <p>Immediate cause (a) <u>Asphyxia</u></p> <p>DUE TO</p> <p>Antecedent cause(s) (b) <u>Bronchopneumonia</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>John D. Malone (Hathbillion)</u>		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.		DATE SIGNED <u>12-27-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>12-30-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Park Heights</u>	
LOCATION (City, town, or county) (State): <u>Brunswick Md</u>		24. FUNERAL DIRECTOR		ADDRESS	
DATE REC'D BY LOCAL REG. <u>JAN 3 1956</u>		REGISTRAR'S SIGNATURE <u>Amanda Conway</u>		<u>C.H. Tilt & Son Brunswick Md</u>	

RECEIVED

JAN 4 1956

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12212

12230

CERTIFICATE OF DEATH

Reg. Dist. No. 531

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince George</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cheverly</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Geo Gen. Hosp</u>		STATE <u>Maryland</u> COUNTY <u>Prince George</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Carmody Hills</u> STREET ADDRESS (If rural give location) <u>504-74th St</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Ronald MICHAEL Carter</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec 19 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>30 Nov 1955</u>
9. AGE last birthday: <u>19</u> yrs.		10. IF UNDER 1 YEAR: Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE INFANT - NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>NONE</u>	
11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Warren Carter</u>		14. MOTHER'S MAIDEN NAME: <u>JEANNE ESTELLE MAC CORD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT & ADDRESS: <u>WARREN G. CARTER - 504-74th St</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>751X Purulent Meningitis</u>		<u>48 hours</u>	
ANTECEDENT CAUSE (S) (B) <u>Purulent Hydrocephalus</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Spina Bifida & Meningocele</u>		<u>19 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 12</u> , 19 <u>55</u> , to <u>Dec 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 19</u> , 19 <u>55</u> , and that death occurred at <u>12:48 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Max W. Herzberg</u>		M. D. <u>Seal Messant M.D.</u> DATE SIGNED <u>12-19-55</u>	
23. BURIAL, CREMATION, REBURY (Specify)		DATE THEREOF	
<u>BURIAL</u>		<u>12/21/1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>ARLINGTON NATL CEM.</u>		<u>ARLINGTON VA.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>12/20/55</u>		<u>Manda Dorney</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>W.W. CHAMBERS CO - Riverdale, Md.</u>			

BUREAU V. S.

DEC 22 1955

RECEIVED

12231

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 12213

No. 231

1. PLACE OF DEATH:

COUNTY Prince George's MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cheverly, Maryland

LENGTH OF STAY (in this place) D. O. A.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince George's General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Prince George's

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Hyattsville, Md.

STREET ADDRESS (If rural, give location) 4204 Gallatin Street,.

3. NAME OF DECEASED: (First) (Middle) (Last)

(Type or Print) JAMES ARCHIBALD CHISHOLM

4. DATE OF DEATH (Month) (Day) (Year)

December 16, 19 55.

5. SEX: 6. COLOR OR RACE: 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): 8. DATE OF BIRTH: 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

male white Married Feb 14, 1877 78 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): 10b. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY?

Watchman Sanitary Commissioner Missouri U. S. A.

13. FATHER'S NAME:

John Hoy Chisholm

14. MOTHER'S MAIDEN NAME:

Rebecca Friend

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

Yes Spanish American

16. SOCIAL SECURITY No.:

578-36-6158

17. INFORMANT & ADDRESS:

Joseph R. Chisholm-

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) Pulmonary edema

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Arteriosclerotic heart disease

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Hypertension

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH

20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at Not while work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John J. Maloney (Hyattsville, Md.)

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED

DEPUTY MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAM. ☐

12-16-55

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

Dec 20, 1955

NAME OF CEMETERY OR CREMATORY

Arlington National

LOCATION (City, town, or county)

Arlington, Va

(State)

DATE REC'D BY LOCAL REG.

12/20/55

REGISTRAR'S SIGNATURE

Amanda L. Lohrey

24. FUNERAL DIRECTOR

F. Pasch's sons Hyattsville Md.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 51

DEC 22 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12214

12287

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5717 - Rutan</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u> STREET ADDRESS <u>5717 - Rutan</u>	
3. NAME OF DECEASED (Type or Print) <u>JOSEPH</u> (First) <u>B</u> (Middle) <u>CHLOPICKI</u> (Last)	4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>27</u> (Year) <u>1955</u>	5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>AUG 24, 1884</u>	9. AGE last birthday <u>73</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>
11. BIRTHPLACE (State or foreign country) <u>Poland</u>	12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	13. FATHER'S NAME <u>Victor Chlopicki</u>	14. MOTHER'S MAIDEN NAME <u>Matilda Serwatowski</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY No. <u>577-10-7838</u>	17. INFORMANT AND ADDRESS <u>Gladys Chlopicki, same</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
177X Immediate cause (a) <u>Acute congestive heart failure</u> (b) <u>Carcinoma of prostate with</u> (c) <u>metastasis</u>		<u>2 hr</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>1950</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of prostate</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE <u>Heir</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/27</u> , 19 <u>55</u> , and that death occurred at <u>10:30</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>Edgar E. Ferine M.D.</u>		ADDRESS <u>College Park Md</u>	DATE SIGNED <u>12/27/55</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>12/30/1955</u>	NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>	LOCATION (City, town, or county) (State) <u>COLMAR MARION, P.D.C. MD</u>
DATE REC'D BY LOCAL REG. <u>Dec 29-1955</u>	REGISTRAR'S SIGNATURE <u>John D Smith</u>	24. FUNERAL DIRECTOR <u>W.W. Chambers Co - Riverdale, Md</u>	ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 30 1955

RECEIVED

12232

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince George's</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>P.G.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
38 TOWN <u>Chesley</u>		5 days		14 TOWN <u>College Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
77 <u>Prince George's General Hospital</u>				10021 Washington - Baltimore			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Donald Eugene Coffey</u>				12 / 26 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Single	1/21/55	— yrs.	11 Months	5 Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
INFANT			NONE	Md.		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>WADE LEROY COFFEY</u>				<u>EVELYN ELIZABETH EDWARDS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
NO		NONE		Statistic Card			
15. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
571.0 IMMEDIATE CAUSE (A) <u>Severe acidosis</u>						1 week	
ANTECEDENT CAUSE (B) <u>Dehydration</u>						1 week	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Severe gastric enteritis</u>						1 week	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
0							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-25, 1955, to 12/26, 1955, that I last saw the deceased alive on 12/26, 1955, and that death occurred at 8:20 A.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>R.D. Baker</u>		<u>Hyattsville Md.</u>		<u>12-26-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12/28/1955</u>		<u>GOV. WASH. CEMETERY</u>		<u>RIGGS RD EXTENDD-PR. GOV. CO., MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12/28/55</u>		<u>Amanda Downey</u>		<u>W.W. CHAMBERS Co - RIVERDALE, MD</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 29 1955

BUREAU V. S.

12233

CERTIFICATE OF DEATH

Reg. Dist. No. 259

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince Georges</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>P.G.</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>38</i> <i>Chewerly</i>		LENGTH OF STAY (in this place) <i>17 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Laurel</i> <i>41</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>77</i> <i>Prince Georges General Hospital</i>				STREET ADDRESS (If rural give location) <i>Washington Blvd.</i>			
3. NAME OF DECEASED: (First) <i>Thomas</i> (Middle) (Last) <i>COON</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>12/2</i> 19 <i>55</i>			
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W. Coon</i>	8. DATE OF BIRTH: <i>8-23-1878</i>	9. AGE last birthday <i>77</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>watchman</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>private industry</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Thomas Coon</i>				14. MOTHER'S MAIDEN NAME: <i>Margaret Shiner</i>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <i>Statistic Card</i>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Bronchopneumonia</i>							<i>5 DAYS</i>
ANTECEDENT CAUSE (B) <i>Congestive Heart Failure</i>							<i>20 DAYS</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Arteriosclerotic Heart Disease</i>							<i>3 YEARS</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>2</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11/15</i> , 19 <i>55</i> , to <i>12/2</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12/2</i> , 19 <i>55</i> , and that death occurred at <i>12:05</i> PM, from the causes and on the date stated above.							
SIGNATURE <i>Morgan Donet Coon</i>				ADDRESS <i>3503 Penny St Mt Rainier Md</i>		DATE SIGNED <i>12/2/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Dec. 4 1955</i>		NAME OF CEMETERY OR CREMATORY <i>St. Marks Cemetery</i>		LOCATION (City, town, or county) (State) <i>Highland, Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Dec. 4-1955</i>		REGISTRAR'S SIGNATURE <i>Morgan Donet Coon</i>		24. FUNERAL DIRECTOR <i>Alc. With Cavalley Laurel Md.</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 8 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12217

12288 CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Pr. Geo.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Landover		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Landover	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) 3605 - 65th. Avenue	
3. NAME OF DECEASED (First) (Middle) (Last) Jerome J Crow		4. DATE OF DEATH (Month) (Day) (Year) Dec. 13 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 20, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator		10b. KIND OF BUSINESS OR INDUSTRY Woodward & Loth	9. AGE last birthday 71 yrs.
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis F. Crow		14. MOTHER'S MAIDEN NAME Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. 577-01-4433	
17. INFORMANT Mrs. Mildred Quigley			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
Immediate cause

(a) Cereb. v. ascula hemorrhage - Left

INTERVAL BETWEEN ONSET AND DEATH

2 days

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cereb. vascul. hemorrhage, Right

5 mrs

(c) Cerebral arteriosclerosis

Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

None

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 1954, to Dec. 13, 1955, that I last saw the deceased alive on Dec. 13, 1955, and that death occurred at 2:45 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree & title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL SOCIETY (with location, if rural)	(STATE)
Burial	12/16/55	Mt. Olivet Cemetery	Washington, D.C.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec. 15, 1955	Wanda Sweeney	Walley's Funeral Home Inc.	3200 R. I. Ave Mt. Rainier, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

12/20/55

BUREAU V. S.

DEC 22 1955

RECEIVED

12234 CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince Georges</i>	STATE <i>md.</i> COUNTY <i>Pv. Geo.</i>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Chesley</i>	LENGTH OF STAY (in this place) <i>36 hrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Landover Hills</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Prince Georges Hospital</i>	STREET ADDRESS (If rural give location) <i>3906-70th Ave</i>		
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Baby Boy</i>	(Middle) <i>Dameron</i>	(Last) <i>Dameron</i>	(Month) <i>12</i> (Day) <i>11</i> (Year) <i>1955</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify): <i>12-10-55</i>	8. DATE OF BIRTH:
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		yrs. Months Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>md.</i>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME: <i>John Dameron</i>		14. MOTHER'S MAIDEN NAME: <i>Agnes Farrell</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <i>mother - as above</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE <i>763.0</i>		
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(A) <i>Neonatal lobar emphysema</i>		
DUE TO <i>of left lower lobe</i>		
(B) <i>uric acid infarcts of kidney</i>		
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from *12/10/55* 19*55*, to *12/11/55* 19*55*, that I last saw the deceased alive on *12/11* 19*55*, and that death occurred at *10:20* P.M. from the causes and on the date stated above.

SIGNATURE <i>William Brannin</i>	DATE SIGNED <i>12/10/55</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	DATE THEREOF <i>December 55</i>
NAME OF CEMETERY OR CREMATORY <i>Prince Georges Hosp</i>	LOCATION (City, town, or county) <i>Chesley Md</i>
DATE REC'D BY LOCAL REGISTRAR <i>12/15/55</i>	REGISTRAR'S SIGNATURE <i>Amanda Downey</i>
24. FUNERAL DIRECTOR <i>Sam W. Ben</i>	ADDRESS <i>11 St</i>

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 19 1955

RECEIVED

12235
CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Prince Georges MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chantilly, Md.	STATE Maryland COUNTY Pr. Geo.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Suitland, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pr. Geo. Gen. Hosp.	LENGTH OF STAY (in this place) 3 days	STREET ADDRESS (If rural give location) 4510 Suitland Rd.	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
Gussie MARY Dean		DEATH: DEC. 28 1955	
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: 4-1-14
9. AGE last birthday 41 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HSWF		10B. KIND OF BUSINESS OR INDUSTRY: TENERY	
11. BIRTHPLACE (State or foreign country): MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: UNKNOWN		14. MOTHER'S MAIDEN NAME: ELLA SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: JAMES DEAN		SAME AS ABOVE	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
342X IMMEDIATE CAUSE		(A) Brain abscess (rt. temp. lobe)	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 12-28, 1955, and that death occurred at 5 P.M. from the causes and on the date stated above			
SIGNATURE Samuel M. Sugar		M. D. M. Rammer MD 12/28/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/31/55	
NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
DATE REC'D BY LOCAL REGISTRAR 1/3/56		REGISTRAR'S SIGNATURE Amanda Downey	
24. FUNERAL DIRECTOR Ritchie Bros.		ADDRESS Upper Marlboro, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 5 1956

BUREAU V. S.

1955
- 411
1914

12289

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12220
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 242

1. PLACE OF DEATH:

COUNTY Prince George's

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN Largo Md.

LENGTH OF STAY
(in this place)
TransitHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Central Avenue,.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Washington COUNTY D. C.

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN Washington D. C.

STREET
ADDRESS

(If rural, give location)

308 Livingston Road,.

3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

Ivan

Paul

Donaldson

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

12 31

19 55

5. SEX:

male

6. COLOR OR
RACE:

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): Single

8. DATE OF BIRTH:

June 21, 1938

9. AGE last birthday:

17

yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):

Box Builder

10b. KIND OF BUSINESS OR
INDUSTRY:

David Max Company

11. BIRTHPLACE (State or foreign country):

Washington D. C.

12. CITIZEN OF WHAT
COUNTRY?

U S A

13. FATHER'S NAME:

Charles E. Donaldson

14. MOTHER'S MAIDEN NAME:

Madeline Donovan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

no

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Charles E. Donaldson Washington D. C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN
ONSET AND DEATH21a. EXTERNAL CAUSE WAS
PRIMARY ☒ or CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY)

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY 12 31 55 2:4 A.M.21e. INJURY OCCURRED
While at work ☐ Not while
at work ☒

21f. HOW DID INJURY OCCUR

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and
find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BUREAU V. S.

JAN 5 1956

RECEIVED

13-31-56

12236

12221
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 245

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince Georges</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Pr. Geo. Co</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <i>Thurldale</i>		<i>20.9.</i>		TOWN <i>East Riverdale</i>		<i>25</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Selma Memorial Hosp.</i>				STREET ADDRESS (If rural, give location) <i>5415 - Carter's Lane</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>George William Thomas Edney</i>				<i>12-21-1955</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>Married</i>		8. DATE OF BIRTH: <i>2-23-02</i>	
						9. AGE last birthday: <i>53</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Pipe fitter</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>U.S. Navy Yard</i>		11. BIRTHPLACE (State or foreign country): <i>N. Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.G.</i>	
13. FATHER'S NAME: <i>William C. Edney</i>				14. MOTHER'S MAIDEN NAME: <i>Sallie J. Johnson</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No.: <i>Unk.</i>		17. INFORMANT'S ADDRESS: <i>Bessie Mae Edney - same address.</i>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause		(a) <i>Acute congestive heart failure</i>			
DUE TO					
Antecedent cause(s)		(b) <i>Chronic valvular heart disease and</i>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		DUE TO			
		(c) <i>Cardiovascular renal disease</i>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
<i>John J. Maloney (Hyattsville, Md)</i>		DEPUTY MEDICAL EXAMINER		<i>12-21-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>12/24/55</i>		NAME OF CEMETERY OR CREMATORY: <i>Oakland Cemetery</i>	
				LOCATION (City, town, or county) (State): <i>Gaffney Cherokee S. Carolina</i>	
DATE REC'D BY LOCAL REG: <i>12/23/55</i>		REGISTRAR'S SIGNATURE: <i>Umaida D. Gurney</i>		24. FUNERAL DIRECTOR ADDRESS: <i>F. Gasch's Sons Hyattsville, Maryland</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 29 1955

BUREAU V. S.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Prince Georges	MARYLAND	STATE D. C.	COUNTY -
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Glenn Dale (rural)	LENGTH OF STAY (in this place) 7 mos. & 8 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington	47X-3
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS (If rural, give location) 803 N. J. Ave., N. W.	✓
3. NAME OF (First) (Middle) (Last) DECEASED: Walter Everett		4. DATE (Month) (Day) (Year) OF DEATH: 12 4 1955	
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Jan. 3, 1925
9. AGE last birthday: 30 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Upholsterer		10b. KIND OF BUSINESS OR INDUSTRY: Lewis Upholstery	11. BIRTHPLACE (State or foreign country): Selma, N. C.
13. FATHER'S NAME: Jesse Everett		14. MOTHER'S MAIDEN NAME: Sadie Mae Foster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes		16. SOCIAL SECURITY NO.: 245-30-0008	
17. INFORMANT & ADDRESS: Decedent		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
158x Immediate cause (a) Retrosperitoneal Sarcoma		8 months	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: 12/8/43		19b. MAJOR FINDINGS OF OPERATION: 245-30-0008	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work Not while at work	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 25 1955, to Dec 4, 1955, that I last saw the deceased alive on Dec 7, 1955, and that death occurred at 11:45 Am., from the causes and on the date stated above.			
SIGNATURE Daniel Leo Punicane		(DEGREE OR TITLE) ADDRESS Glenn Dale Hospital	
23. BURIAL, CREMATION REMOVAL (Specify): Removal to		NAME OF CEMETERY OR CREMATORY Glenn Dale, Md.	
DATE REC'D BY LOCAL REG. 12/4/55		LOCATION (City, town, or county) Washington, D.C.	
24. FUNERAL DIRECTOR		ADDRESS	

RECEIVED

DEC 9 1955

BUREAU V. S.

1222343

12291

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Prince Georges	MARYLAND	STATE D. C.	COUNTY -
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glenn Dale (rural)	LENGTH OF STAY (in this place) 5 yrs., 11 mos. & 11 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington	478-3
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS 66 New York Ave., N.W.	
3. NAME OF DECEASED: (First) JOSEPH (Middle) (Last) FEIFER		4. DATE OF DEATH: (Month) 12 (Day) 11 (Year) 19 55.	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 12/28/1892
9. AGE last birthday: 62 yrs.		10. IF UNDER 1 YEAR: Months 11 Days 13 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Tailor		10b. KIND OF BUSINESS OR INDUSTRY: Unknown	
11. BIRTHPLACE (State or foreign country): Russia		12. CITIZEN OF WHAT COUNTRY? Questionable	
13. FATHER'S NAME: Leib Feifer		14. MOTHER'S MAIDEN NAME: Rose Sheihett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 578-38-9925	
17. INFORMANT & ADDRESS: Decedent			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause (a) Cor pulmonale		14 1/2 years	
Antecedent causes (s) (b) Pulmonary Tuberculosis		6 yrs.	
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: 0		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-30, 19 49, to 12-11, 19 55, that I last saw the deceased alive on 12-10, 19 55, and that death occurred at 4:45 A.M. from the causes and on the date stated above.			
SIGNATURE Daniel Lee Francisco MD		DATE SIGNED 12/11/55	
HOSPITAL (Specify) BURIAL		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF 12/12/55		LOCATION (City, town, or county) (State) Washington D.C.	
DATE REC'D BY LOCAL REGISTRAR 12/11/55		REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR		ADDRESS	
Bernard Mangansky & Son		Washington, D.C.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 20 1955

RECEIVED

12292

CERTIFICATE OF DEATH

Reg. Dist. No. 12224
272

1. PLACE OF DEATH: 5810 - L - ST. N.E. FAIRMOUNT HEIGHTS COUNTY PRINCE GEORGES MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN FAIRMOUNT HEIGHTS 8 Yrs. HOSPITAL OR INSTITUTION OR STREET ADDRESS 5810 - L - ST - N.E.				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD. COUNTY PR. GEO. CITY (If outside corporate limits, write RURAL and give nearest town) TOWN FAIRMOUNT HEIGHTS STREET ADDRESS (If rural give location) 5810 - L - ST - N.E.			
3. NAME OF DECEASED: (First) (Middle) (Last) Mable Tolliver Ferguson				4. DATE OF DEATH: 12 28 1955			
5. SEX: F		6. COLOR OR RACE: C		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED		8. DATE OF BIRTH: JAN 25 1887	
9. AGE last birthday: 68 yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Housewife		11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Charles Franklin				14. MOTHER'S MAIDEN NAME: Alice Gordon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Edward T. Ferguson 5810 L St. N.E.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 490X Immediate cause (a) Lobar pneumonia Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c) Congestive heart failure, Myocarditis						Interval Between Onset And Death 4 days	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work [] Not While At Work []		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1. June, 1955, to 28 Dec., 1955, that I last saw the deceased alive on 28 Dec., 1955, and that death occurred at 11:35 p.m., from the causes and on the date stated above. SIGNATURE: John J. Collins, M.D. ADDRESS: 601 - 48th St. N.E. Wash. D.C. DATE SIGNED: 28 Dec. 1955							
23. BURIAL CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
1-2-1956		Lincoln Memorial		Suitland Rd		Md	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Dec. 29, 1955		Carrie Campbell		Henry S. Washington, Jr.		467 N. St. N.W. D.C.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 5 1956

RECEIVED

12237 CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

COUNTY

Prince Georges MARYLAND

CITY (If outside corporate limits, write RURAL LENGTH OF STAY
OR and give nearest town) (in this place)

25 TOWN Riverdale 18 hrs.

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

76 beland Mem. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md.

COUNTY

Pr. Geo.

CITY (If outside corporate limits, write RURAL and give nearest town)
OR

TOWN Laurel 41

STREET
ADDRESS

Sandy Spring Road

3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

Andrew Caldwell Flester

4. DATE
OF
DEATH:

(Month)

(Day)

(Year)

12 31 19 55

5. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

8. DATE OF BIRTH:

9. AGE last birthday: 83 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.10a. USUAL OCCUPATION Give kind of
work done during most of working life,
even if (retired)10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME:

Andrew Flester

14. MOTHER'S MAIDEN NAME:

Mary Aitcheson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Niece

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

cerebral thrombosis

Antecedent causes (s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.

(b)

DUE TO

arteriosclerosis

(c)

Interval Between
Onset And Death

4 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg, etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from August 1955, to Dec 31, 1955, that I last saw the deceased

alive on Dec 31, 1955, and that death occurred at 11:35 pm, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Robert S. McGary MD

402 Main St. Laurel Md 12/31/55

23. BURIAL, CREMATION,
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan 2 - 1956 Mrs. Jas. Severe Deputy

Newell Davidson, Laurel Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 9 1956

RECEIVED

12238

CERTIFICATE OF DEATH

Reg. Dist. No. 231

See: Baby B Cert.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince Georges</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
38 <i>Cheverly</i>		4 days		Upper Marlboro X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
77 <i>Prince Georges General Hospital</i>				1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Baby Girl "A" Ford</i>				<i>12 / 15 19 55</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Female</i>	<i>C.</i>		<i>12-11-55</i>	<i>4</i> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<i>Maryland</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Laurence Ford</i>				<i>Mary Ford</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
(If Yes, give war or dates of service)				<i>Mothers' Statistic Card</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
776X IMMEDIATE CAUSE				(A) <i>Prematurity (600 gms 33 cm.)</i>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <i>12/11/55</i> , 19 <i>55</i> , to <i>12/15/55</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12/15/55</i> , 19 <i>55</i> , and that death occurred at <i>10:35</i> AM, from the causes and on the date stated above.							
SIGNATURE <i>John W. Rubin</i>				ADDRESS <i>5301 Hamilton St., Hyattsville 1/2</i>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Cremation</i>		<i>Jan. 1956</i>		<i>Prince Georges Gen Hosp</i>		<i>Cheverly Md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>1/19/56</i>		<i>Amanda Downey</i>		<i>John W. Rubin</i>		<i>Sept</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 31

JAN 17 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12239 CERTIFICATE OF DEATH

Reg. Dist. No. 12586 231

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince Georges</i> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cherry, Md</i>	STATE <i>md.</i> COUNTY <i>Pr. Ges.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Upper Marlboro, Md</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Prince Georges Gen. Hosp.</i>	LENGTH OF STAY (in this place) <i>14 hrs. 17 min.</i>	STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Baby B Girl Ford</i>		DEATH: <i>Dec. 12, 1955</i>	
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>C</i>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH: <i>Dec. 11, 1955</i>
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
		Hours	Min.
			<i>14 17</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Md.</i>
13. FATHER'S NAME: <i>Lawrence Ford</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Hampton</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT'S ADDRESS: <i>mother - as above</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <i>762.5</i>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <i>Atelectasis</i>			
(B) <i>Prematurity</i>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<i>0</i>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>12/4/55</i> , 19 <i>55</i> , to <i>12/12</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12/12</i> , 19 <i>55</i> , and that death occurred at <i>10:05 A</i> M, from the causes and on the date stated above.			
SIGNATURE <i>John W. Rubin</i>		ADDRESS <i>M. D. 5301 Hamilton St. Hyattsville, Md</i>	
DATE SIGNED <i>12/12/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Interment</i>		DATE THEREOF <i>Jan 1956</i>	
NAME OF CEMETERY OR CREMATORY <i>Prince Georges Ar. Cemetery, Md</i>		LOCATION (City, town, or county) <i>Cherry, Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>1/14/56</i>		REGISTRAR'S SIGNATURE <i>Amarch Dawson</i>	
24. FUNERAL DIRECTOR <i>William W. Penn</i>		ADDRESS <i>Capit</i>	

BUREAU V. S.

JAN 17 1956

RECEIVED

12225
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 245

Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE Md		COUNTY Prince George	
CITY (If outside corporate limits, write name of nearest town) Hyattsville		LENGTH OF STAY (in this place) Transit		CITY (If outside corporate limits write name of nearest town) Bladensburg		33	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Police Station				STREET ADDRESS 4903-49th Place		(If rural, give location)	
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) Worthen		(Middle) Fox		(Last) Fox		(Month) 12- (Day) 19- (Year) 1955	
5. SEX: Male		6. COLOR OR RACE: Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 11/19/1911	
9. AGE last birthday: 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer		11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Louis Fox				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY No.:			
17. INFORMANT & ADDRESS: Shirley Fox - Same address -							

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) Toxemia - cerebral edema		DUE TO			
Antecedent cause(s) (b) Bilateral lobar pneumonia		DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, of street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
SIGNATURE John W. Maloney (Hyattsville, Md)		CHIEF MEDICAL EXAMINER		DATE SIGNED 12-19-55	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF: 12/19/55		NAME OF CEMETERY OR CREMATORY: Washington D.C.	
DATE REC'D BY LOCAL REG: 12/19/55		REGISTRAR'S SIGNATURE: Mrs. Jas. - Severe		24. FUNERAL DIRECTOR: Robert G. Sinc line 1820-9257 N.W. Wash. D.C.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 29 1955

BUREAU V. S.

12240

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u> MARYLAND				STATE <u>md</u> COUNTY <u>Pr. Geo.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>			
TOWN <u>Chesley</u>				TOWN <u>Brandywine</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen. Hosp.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>George Edgar Frye</u>				OF DEATH: <u>Dec. 28</u> <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>W</u>		8. DATE OF BIRTH: <u>5-26-86</u>	
9. AGE last birthday: <u>69</u> yrs.		IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS.: Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>attendant</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Cedar Hill Country</u>		11. BIRTHPLACE (State or foreign country): <u>Waterford, Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>George H. Frye</u>				14. MOTHER'S MAIDEN NAME: <u>Clara E. Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>579-01-9419</u>		17. INFORMANT & ADDRESS: <u>A. Elmer Frye Brother</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Carcinoma of tongue</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>11-9</u> , 19 <u>55</u> , to <u>12-26</u> 19 <u>55</u> , that I last saw the deceased alive on <u>12-26</u> , 19 <u>55</u> , and that death occurred at <u>4:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>John F. Davis</u>				M. D.		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/31/55</u>		<u>Cedar Hill</u>		<u>Scitland, Pr. Georges, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Dec 31 1955</u>		<u>Amanda Dourney</u>		<u>Wiley's Funeral Home, Inc.</u>		<u>3200 R. S. Ave. Mt. Rainier, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 5 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12241

CERTIFICATE OF DEATH

Reg. Dist. No.

12227

231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u> MARYLAND				STATE <u>W. Va.</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chewerly Md.</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Martinsburg 95X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen. Hosp.</u>				STREET ADDRESS (If rural give location) <u>Stephens St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Melvin</u> <u>Trye</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec. 27</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M.</u>	8. DATE OF BIRTH: <u>Feb. 6, 1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>	
13. FATHER'S NAME: <u>Ralph Trye</u>				14. MOTHER'S MAIDEN NAME: <u>Melvinia Kendrick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Emma B. Trye Martinsburg W. Va.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
451X IMMEDIATE CAUSE (A) <u>Perforated aneurysm of aorta.</u>						<u>2 days</u>	
ANTECEDENT CAUSE (S) (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY; street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/25</u> , 19 <u>55</u> , to <u>12/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/27</u> , 19 <u>55</u> , and that death occurred at <u>5:15 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Frederick E. Munner</u>		M. D. <u>79096 Avenue St</u>		DATE SIGNED <u>12/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		LOCATION (City, town, or county) (State) <u>Martinsburg W. Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/28/55</u>		REGISTRAR'S SIGNATURE <u>Amanda Downey</u>		24. FUNERAL DIRECTOR <u>Howard K. Brown</u>		ADDRESS <u>Martinsburg W. Va.</u>	

BUREAU V. S.

JAN 2 1956

RECEIVED

12242

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince Georges</u>	MARYLAND	STATE <u>—</u>	COUNTY <u>—</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Chesley</u>	LENGTH OF STAY (in this place) <u>26 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges General Hospital</u>		STREET ADDRESS (If rural give location) <u>1403 Crittenden Street</u>	
3. NAME OF DECEASED: (First) <u>Benjamin</u> (Middle) <u>—</u> (Last) <u>Forman</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>12 - 24</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married - W.</u>	8. DATE OF BIRTH: <u>3-1-1902</u>
9. AGE last birthday <u>53</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>?</u>
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>9</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>Statistic Card</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of Bladder</u>			<u>6 months</u>
ANTECEDENT CAUSE (B) <u>—</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>—</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>68</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I attended the deceased from <u>11/28</u> , 19 <u>55</u> , to <u>12/24</u> , 19 <u>55</u> that I last saw the deceased alive on <u>12/24</u> , 19 <u>55</u> , and that death occurred at <u>6 P.</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Amelia C. Rea</u>		DATE SIGNED <u>12/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>12/24/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Washington DC</u>		LOCATION (City, town, or county) (State) <u>Washington DC</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/24/55</u>	REGISTRAR'S SIGNATURE <u>Amelia C. Rea</u>	24. FUNERAL DIRECTOR <u>B. Dungan & Son</u>	ADDRESS <u>Wash. DC</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 28 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12293
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12229
 Reg. Dist. No. 242

1. PLACE OF DEATH: COUNTY <u>Prince George's</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>District Heights</u> LENGTH OF STAY (In this place) <u>2 years</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3121 Ramblewood Drive</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Prince George's</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>District Heights</u> STREET ADDRESS (If rural, give location) <u>3121 Ramblewood Drive</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Anne Elizabeth Gaskin</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>12 15 1955</u>				
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>			
8. DATE OF BIRTH: <u>June 6, 1896</u>		9. AGE last birthday: <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington DC</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME: <u>Samuel Gaskin</u>				
14. MOTHER'S MAIDEN NAME: <u>Ada Collins</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY No.:			17. INFORMANT & ADDRESS: <u>Alma Haardt, 3119 Ramblewood Dr, District Heights</u>				

18. MEDICAL CERTIFICATION 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>acute congestive heart failure</u> DUE TO Antecedent cause(s) (b) <u>cardiovascular renal disease</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION: <u>12/19/55</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Samuel J. T. Saffell</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> <u>12-15-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>12/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	
LOCATION (City, town, or county) (State) <u>Washington DC</u>		24. FUNERAL DIRECTOR <u>T. Saffell</u>		ADDRESS <u>4754 7th St NW Washington DC</u>	
DATE REC'D BY LOCAL REG. <u>12/17/55</u>		REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>		24. FUNERAL DIRECTOR ADDRESS	

RECEIVED

DEC 27 1955

BUREAU V. S.

12243

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Pr. Georges</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		STATE <u>Md.</u> COUNTY <u>Pr. Georges</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
TOWN <u>125</u>		LENGTH OF STAY (in this place) <u>9 hrs.</u>		OR TOWN <u>14</u>		STREET ADDRESS (If rural give location) <u>9110-48th Pl.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beland Mem. Hosp.</u>				10. AGE last birthday <u>50</u> yrs.			
3. NAME OF DECEASED: (Type or Print) (First) <u>Walter</u> (Middle) <u>S.</u> (Last) <u>Gianoly</u>				4. DATE OF DEATH: (Month) <u>12</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>12-8-04</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Cost Accountant</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Dept. Defense</u>		11. BIRTHPLACE (State or foreign country): <u>Mo.</u>	
13. FATHER'S NAME: <u>Albert Gianoly</u>				14. MOTHER'S MAIDEN NAME: <u>Frances</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS: <u>Wife</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Intracranial hemorrhage</u>							<u>2 wks.</u>
ANTECEDENT CAUSE (S) (B) <u>Cerebral arteriosclerosis</u>							<u>years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>generalized arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>DEC. 3, 1955</u> , to <u>DEC. 3, 1955</u> , that I last saw the deceased alive on <u>Dec. 3, 1955</u> , and that death occurred at <u>9:29 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. J. Housman</u>			M. D. <u>Riverdale</u>			DATE SIGNED <u>DEC. 3 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			DATE THEREOF <u>Dec 6, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>Dec. 5, 1955</u>			REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severeid</u>			24. FUNERAL DIRECTOR <u>F. Gasche Sons, Hyattsville, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 6 1955

BUREAU V. S.

12244

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

COUNTY Prince George MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Laurel
 OR and give nearest town
 TOWN Laurel
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 501 Gorman Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Pr. Geo.
 CITY (If outside corporate limits, write RURAL and give nearest town) Laurel
 OR TOWN Laurel
 STREET ADDRESS (If rural give location) 501 Gorman Ave

3. NAME OF DECEASED:

(First) Albert (Middle) L. (Last) Garnell

4. DATE OF DEATH: (Month) Dec. (Day) 2 (Year) 1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday: 87 yrs. IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2
 Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

Interval Between Onset And Death

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office, etc.) Home

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY None m.

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/21, 1955, to 12/2, 1955, that I last saw the deceased

alive on 12/2, 1955, and that death occurred at 10:40 PM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

RECEIVED

DEC 6 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12245

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 1232
No. 231

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince Georges</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Prince Georges</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Chesley</u>	LENGTH OF STAY (in this place) <u>D.O.G.</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>Brentwood</u>	<u>34</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen Hosp</u>		STREET ADDRESS (If rural, give location) <u>4514-40th Street</u>	
3. NAME OF DECEASED: (Type or Print) <u>Susie - Graham</u>		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>21</u> (Year) <u>1953</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH: <u>Jan-24, 1896</u>
9. AGE last birthday: <u>59</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Wash Thompson</u>		14. MOTHER'S MAIDEN NAME: <u>Lettie Anderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>Daughter - Same address.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute congestive heart failure</u>			
DUE TO			
Antecedent cause(s) (b) <u>Hypertensive cardiovascular disease</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.			
SIGNATURE <u>John J. Maloney Hyattsville, Md.</u>		DATE SIGNED <u>12-21-53</u>	
CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER	
ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>12/27/53</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cemetery</u>	LOCATION (City, town, or county) (State) <u>Arlington Va.</u>
DATE REC'D BY LOCAL REG. <u>12/22/53</u>	REGISTRAR'S SIGNATURE <u>Manuela Downey</u>	24. FUNERAL DIRECTOR <u>Robert G. McQuinn</u>	ADDRESS <u>1826-9th St. Wash. D.C.</u>

BUREAU V. S.

DEC 27 1955

RECEIVED

Clifford M. Gentry

James

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

12233

245

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hyattsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hyattsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>3135 - Nicholson street</u>	
3. NAME OF DECEASED (Type or Print) <u>Patrick</u>		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>3/5/1892</u>	
9. AGE last birthday <u>63</u> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman Government Printing Office</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cambridge, Mass.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Salavatore Greco</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Bensaia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Joseph S. Greco (Son)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a) <u>Hypostatic Pneumonia</u>		<u>2 days</u>
Antecedent cause(s) (b) <u>Paraplegia</u>		<u>6 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Myocarditis</u>		<u>6 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bacteria sclerosis</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-2- 1954, to 12-18 1955, that I last saw the deceased alive on 12-18 1955, and that death occurred at 8:30 P m., from the causes and on the date stated above.

SIGNATURE <u>John L. DeMaya M.D.</u>	DATE SIGNED <u>12-18-55</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>12/19/55</u>
NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
DATE REC'D BY LOCAL REG. <u>Dec 20, 1955</u>	REGISTRAR'S SIGNATURE <u>James Severy</u>
24. FUNERAL DIRECTOR <u>Galley's Funeral Home</u>	ADDRESS <u>3200-R. P. Ave. Mt Rainier Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 23 1955

BUREAU V. S.

12246

Items 13 & 14, Film G190, 12/12/55 bn

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince George's</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Prince George's</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Chesley, Md.</i>				TOWN <i>Chapel Oaks</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Prince George's Dr. Hosp.</i>				STREET ADDRESS (If rural give location) <i>1105 - 57th Place</i>			
3. NAME OF DECEASED: (First) <i>Charles</i> (Middle) <i>Green</i> (Last) <i>Green</i>				4. DATE (Month) <i>Dec.</i> (Day) <i>2</i> (Year) <i>1955</i>			
5. SEX: <i>m</i>		6. COLOR OR RACE: <i>C</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>11-30-1889</i>	
				9. AGE last birthday <i>66</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Washington, D.C.</i>	
						12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>James Green</i>				14. MOTHER'S MAIDEN NAME: <i>Catherine (Unknown)</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Statistic Card</i>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
491X IMMEDIATE CAUSE (A) <i>Broncho-Pneumonia</i>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Paraplegia due to Tuberculous Thrombosis; Spinal</i>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at <i>6 A.</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Charles A. Rath</i>				M. D. <i>Never doly</i>		DATE SIGNED <i>12-2-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-9-55</i>		NAME OF CEMETERY OR CREMATORY <i>Lincoln Mem.</i>		LOCATION (City, town, or county) (State) <i>Seatland Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Dec. 4, 1955</i>		REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>		24. FUNERAL DIRECTOR <i>FPAZIER'S</i>		ADDRESS <i>389 P.I. Ave</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 6 1955

BUREAU V. B.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12247

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12235
Reg. Dist.

No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE Md		COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Chesley		LENGTH OF STAY (in this place) 2.0.9.		CITY (If outside corporate limits write RURAL OR and give nearest town) TOWN Fawcett Heights			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince Georges Gen. Hosp				STREET ADDRESS (If rural, give location) 713 1/2-59th Place			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Fred Greenfield				12 - 14 1955			
5. SEX: male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 10-3-1886	9. AGE last birthday: 69 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Labour		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): New York State		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Bill Greenfield				14. MOTHER'S MAIDEN NAME:			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 5-77-16-0430		17. INFORMANT & ADDRESS: Wife - Same address.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Acute congestive heart failure							
DUE TO							
Antecedent cause(s) (b) Cardiovascular renal disease							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: 12/15/55				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE John J. Maloney (Hyattsville Md)				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-14-55			
23. BURIAL, CREMATION, REMOVAL (Specify): Removal				24. FUNERAL DIRECTOR 7 Busch Son Hyattsville Md			
DATE REC'D BY LOCAL REG. 12/15/55		REGISTRAR'S SIGNATURE Amanda L. Runey		24. FUNERAL DIRECTOR		ADDRESS	

RECEIVED

DEC 19 1955

BUREAU V. S.

12248

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince George</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Prince George</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>38 Chelvey</i>	LENGTH OF STAY (in this place) <i>5 Hrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Kentland</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>77 Prince George Gen Hosp</i>		STREET ADDRESS (If rural give location) <i>7617 Lombard ST</i>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>Lida</i>	(Middle) <i>R</i>	(Last) <i>GRIFFIN</i>	DATE: <i>12 / 3 1955</i>
5. SEX: <i>7</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>MARRIED</i>	8. DATE OF BIRTH: <i>9/6/1880</i>
9. AGE last birthday <i>75</i> yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, over or retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>at home</i>	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME: <i>Grafton Smithson</i>	
14. MOTHER'S MAIDEN NAME: <i>Unknown</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>None</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT'S ADDRESS: <i>Mrs. Florence L. Faller, 7617 Lombard St, Kentland Md</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
260X IMMEDIATE CAUSE			
(A) <i>Acute Myocardial Infarction</i>			<i>1 day</i>
ANTECEDENT CAUSE (S)			
(B) <i>Diabetes Mellitus</i>			<i>± 10 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 1, 1955, to 12-3-, 1955, that I last saw the deceased alive on 12-3-, 1955, and that death occurred at 10:37 P. M. from the causes and on the date stated above.			
SIGNATURE <i>Amelia J. Lear</i>		DATE SIGNED <i>12-3-55</i>	
M. D. <i>1314 Gallatin St. Hyattsville, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<i>Burial</i>		<i>12/6/55</i>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Washington Natl Cemetery</i>		<i>Hyattsville, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<i>12/5/55</i>		<i>Amelia Downey</i>	
24. FUNERAL DIRECTOR		ADDRESS	
<i>W.W. Chambers Co.</i>		<i>577-413 ST SE</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 7 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12249
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12237
Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Pr. Geo</u>	
CITY (If outside corporate limits, write OR and give nearest town) TOWN <u>Cheverly</u>		LENGTH OF STAY (in this place) <u>8 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Hillside</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Sin Hosp</u>				STREET ADDRESS (If rural, give location) <u>5113 Benning Road</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Clara Gertrude Groot</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12-11-1953</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>5-1-1885</u>	
9. AGE last birthday: <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Washington, D.C.</u>		11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>Charles L. Mace</u>			
14. MOTHER'S MAIDEN NAME: <u>Clara Hoover</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>None</u>			
16. SOCIAL SECURITY No.: <u>UNKNOWN</u>				17. INFORMANT & ADDRESS: <u>Mrs. Marie Schofield - same address</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Acute congestive heart failure</u>							
DUE TO							
Antecedent cause(s) (b) <u>Cardiovascular renal disease</u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Myocardial - Shock due to severe trauma</u>							
19a. DATE OF OPERATION: <u>11-26-53</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>)		21c. (City or town) (County) (State) <u>Hillside - Prince Georges, MD</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11-26-53 1:00 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>							
SIGNATURE <u>John J. Maloney (Hyattsville, Md)</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-11-53</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE TIME OF <u>12/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM.</u>		LOCATION (City, town, or county) (State) <u>COLMAR MANOR PR. GEORGE MD</u>	
DATE REC'D BY LOCAL REG. <u>12/12/55</u>		REGISTRAR'S SIGNATURE <u>Almunda Downey</u>		24. FUNERAL DIRECTOR <u>W. W. CHAMBERS Co-517-1179 SE.</u>		ADDRESS <u>WASH. D.C.</u>	

BUREAU V. S.

DEC 16 1955

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1

INSTRUCTIONS

1

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12238

12214 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY PRINCE GEORGES		STATE MARYLAND		STATE D. C.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) 15 TOWN HYATTSVILLE		LENGTH OF STAY (in this place) 2 mo.		CITY (If outside corporate limits, write RURAL and give nearest town) WASHINGTON		47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Sacred Heart Home 5805 Queens Chapel Road		STREET ADDRESS (If rural give location) 1499 Irving Street, N. W. ✓					
3. NAME OF DECEASED (Type or Print) JOSEPHINE GUBERNATOR				4. DATE OF DEATH (Month) (Day) (Year) 12 - 16 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 7-27-73	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES GUBERNATOR				14. MOTHER'S MAIDEN NAME CATHERINE RILEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. no		17. INFORMANT & ADDRESS Miss Catherine Metz 3150 -16th. St. N.W. Wash. D.C.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) CEREBRAL VASCULAR HEMORRHAGE						7 days	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/12 , 19 55 , to 12/16 , 19 55 , that I last saw the deceased alive on 12/15 , 19 55 , and that death occurred at 1230A M. from the causes and on the date stated above.							
SIGNATURE <i>James J. Collins</i>				ADDRESS (Street, city, town, state) M.D. 322 H St. N. E. Wash. D.C.		DATE SIGNED 12/16/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-19-55		NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		LOCATION (City, town, or county) (State) Washington, D. C.	
24. REC'D BY REGISTRAR DATE Dec. 18 1955		REGISTRAR'S SIGNATURE <i>Mrs. Jas. Severe</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins</i>		ADDRESS 3821-14th. ST. N.W. Wash. D. C.	

1935

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

Reg. Dist. No.

1. DATE OF DEATH

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF CORONER

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF DEPUTY CONSTABLE

20. SIGNATURE OF JAILER

21. SIGNATURE OF DEPUTY JAILER

22. SIGNATURE OF WARDEN

23. SIGNATURE OF DEPUTY WARDEN

24. SIGNATURE OF CHIEF CLERK

25. SIGNATURE OF DEPUTY CHIEF CLERK

26. SIGNATURE OF ASSISTANT CLERK

27. SIGNATURE OF DEPUTY ASSISTANT CLERK

28. SIGNATURE OF RECORDS CLERK

29. SIGNATURE OF DEPUTY RECORDS CLERK

30. SIGNATURE OF FILE CLERK

31. SIGNATURE OF DEPUTY FILE CLERK

32. SIGNATURE OF INDEX CLERK

33. SIGNATURE OF DEPUTY INDEX CLERK

34. SIGNATURE OF CLERK IN CHARGE

35. SIGNATURE OF DEPUTY CLERK IN CHARGE

36. SIGNATURE OF CLERK AT LARGE

37. SIGNATURE OF DEPUTY CLERK AT LARGE

38. SIGNATURE OF CLERK OF THE COURT

39. SIGNATURE OF DEPUTY CLERK OF THE COURT

40. SIGNATURE OF CLERK OF THE DISTRICT COURT

41. SIGNATURE OF DEPUTY CLERK OF THE DISTRICT COURT

42. SIGNATURE OF CLERK OF THE COUNTY COURT

43. SIGNATURE OF DEPUTY CLERK OF THE COUNTY COURT

44. SIGNATURE OF CLERK OF THE JUDICIAL DISTRICT

45. SIGNATURE OF DEPUTY CLERK OF THE JUDICIAL DISTRICT

46. SIGNATURE OF CLERK OF THE SUPREME COURT

47. SIGNATURE OF DEPUTY CLERK OF THE SUPREME COURT

48. SIGNATURE OF CLERK OF THE HOUSE OF REPRESENTATIVES

49. SIGNATURE OF DEPUTY CLERK OF THE HOUSE OF REPRESENTATIVES

50. SIGNATURE OF CLERK OF THE SENATE

51. SIGNATURE OF DEPUTY CLERK OF THE SENATE

52. SIGNATURE OF CLERK OF THE GOVERNMENT

53. SIGNATURE OF DEPUTY CLERK OF THE GOVERNMENT

54. SIGNATURE OF CLERK OF THE LEGISLATURE

55. SIGNATURE OF DEPUTY CLERK OF THE LEGISLATURE

56. SIGNATURE OF CLERK OF THE JUDICIARY

57. SIGNATURE OF DEPUTY CLERK OF THE JUDICIARY

58. SIGNATURE OF CLERK OF THE EXECUTIVE

59. SIGNATURE OF DEPUTY CLERK OF THE EXECUTIVE

60. SIGNATURE OF CLERK OF THE LEGISLATIVE

61. SIGNATURE OF DEPUTY CLERK OF THE LEGISLATIVE

62. SIGNATURE OF CLERK OF THE JUDICIAL

63. SIGNATURE OF DEPUTY CLERK OF THE JUDICIAL

64. SIGNATURE OF CLERK OF THE EXECUTIVE

65. SIGNATURE OF DEPUTY CLERK OF THE EXECUTIVE

66. SIGNATURE OF CLERK OF THE LEGISLATIVE

67. SIGNATURE OF DEPUTY CLERK OF THE LEGISLATIVE

68. SIGNATURE OF CLERK OF THE JUDICIAL

69. SIGNATURE OF DEPUTY CLERK OF THE JUDICIAL

69. SIGNATURE OF CLERK OF THE EXECUTIVE

70. SIGNATURE OF DEPUTY CLERK OF THE EXECUTIVE

71. SIGNATURE OF CLERK OF THE LEGISLATIVE

72. SIGNATURE OF DEPUTY CLERK OF THE LEGISLATIVE

73. SIGNATURE OF CLERK OF THE JUDICIAL

74. SIGNATURE OF DEPUTY CLERK OF THE JUDICIAL

75. SIGNATURE OF CLERK OF THE EXECUTIVE

76. SIGNATURE OF DEPUTY CLERK OF THE EXECUTIVE

77. SIGNATURE OF CLERK OF THE LEGISLATIVE

78. SIGNATURE OF DEPUTY CLERK OF THE LEGISLATIVE

79. SIGNATURE OF CLERK OF THE JUDICIAL

80. SIGNATURE OF DEPUTY CLERK OF THE JUDICIAL

81. SIGNATURE OF CLERK OF THE EXECUTIVE

82. SIGNATURE OF DEPUTY CLERK OF THE EXECUTIVE

83. SIGNATURE OF CLERK OF THE LEGISLATIVE

84. SIGNATURE OF DEPUTY CLERK OF THE LEGISLATIVE

BUREAU V. 3

DEC 23 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 18 Film 192-2-2-50 ams Item 1, Film 190-12-28-55 et

12239

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH: <u>Edw. Lantz & Prince Georges</u> P. G. COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Near Cheverly</u> OR TOWN <u>Near Cheverly</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Seat Pleasant</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deceased was a patient at Nat. Institutes of Health, Bethesda, Md.</u>				STREET ADDRESS (If rural give location) <u>6408 Greig St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>LINFORD M. HALSTEAD</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>12 11 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, (MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>1/31/08</u>	9. AGE last birthday: <u>47</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>CAB DRIVER</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>self</u>		11. BIRTHPLACE (State or foreign country): <u>CONNELLSVILLE, PA.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>WILLIE HALSTEAD</u>				14. MOTHER'S MAIDEN NAME: <u>Marguerite Ruth.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u>				15. SOCIAL SECURITY NO. <u>579-22-840</u>		17. INFORMANT & ADDRESS: <u>CHART</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u>						<u>15 MEARS</u>	
ANTECEDENT CAUSE (S) DUE TO <u>CORONARY OCCLUSION</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>HYPERTENSION</u>						<u>5 years</u>	
DUE TO <u>NEPHROSCLEROSIS</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.			
21C. WHERE DID (City or town) (County) (State)				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/12/55</u> , 1955, to <u>12/10/55</u> , 1955, that I last saw the deceased alive on <u>12/9</u> , 1955, and that death occurred at <u>6:15</u> P M, from the causes and on the date stated above.							
SIGNATURE <u>B. J. Haverback, M.D.</u>				DATE SIGNED <u>12/10/55</u>			
ADDRESS <u>Edw. Lantz & Prince Georges</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Dec 14, 1955</u>			
NAME OF CEMETERY OR CREMATORY <u>Colesville Methodist</u>				LOCATION (City, town, or county) (State) <u>Colesville, Md.</u>			
24. FUNERAL DIRECTOR <u>F. Gasche Sons Hyattsville Md</u>				ADDRESS <u>Hyattsville Md</u>			
DATE REC'D BY LOCAL REGISTRAR <u>12/12/55</u>				REGISTRAR'S SIGNATURE <u>Amanda D. Kurey</u>			

BUREAU V. S.

DEC 16 1955

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12250

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince Georges</u> MARYLAND	CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Chesley, Md.</u>	STATE <u>md</u> COUNTY <u>Pr Geo.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Upper Marlboro</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen Hosp</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) <u>William</u> (Middle) <u>Harrison</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>12</u> <u>31</u> <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>sep.</u>	8. DATE OF BIRTH: <u>3-14-1900</u>
9. AGE last birthday <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME: <u>Norman Harrison</u>	
14. MOTHER'S MAIDEN NAME: <u>Mary Diggs</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Retrobulbar Abscess</u>			<u>1 month</u>
ANTECEDENT CAUSE (B) <u>Carcinomatosis—primary site undetermined.</u>			<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12-31</u> , 19 <u>55</u> , to <u>8-45</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-31</u> , 19 <u>55</u> , and that death occurred at <u>8-45</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Samuel J. Sugar</u>		DATE SIGNED <u>12/31/55</u>	
M. D. <u>Wm. R. Rimmer</u>		ADDRESS <u>467 8th St NW Wash DC</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>1-7-56</u>	DATE THEREOF	NAME OF CEMETERY OR CREMATORY <u>Mt Carmel Cemetery</u>	LOCATION (City, town, or county) (State) <u>Upper Marlboro Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>1/3/56</u>	REGISTRAR'S SIGNATURE <u>Amanda Sourney</u>	24. FUNERAL DIRECTOR <u>H.S. Washington & Sons</u>	ADDRESS <u>467 8th St NW Wash DC</u>

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JAN 5 1956

RECEIVED

12251

CERTIFICATE OF DEATH

Reg. Dist. No. 231

Item 9, Film G191 1-18-56 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Chesley</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cedar Heights</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen. Hosp.</u>				STREET ADDRESS (If rural give location) <u>64th & Jay Sts.</u>			
3. NAME OF DECEASED: (First) <u>Joseph</u> (Middle) <u>Harrod</u> (Last) <u>Harrod</u>				4. DATE OF DEATH: (Month) <u>12</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>Feb. 22, 1879</u>	9. AGE last birthday: <u>79</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Hillary Harrod</u>				14. MOTHER'S MAIDEN NAME: <u>Harriett ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Bertine Washington (Cousin)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Prostate cancer with metastases</u>						<u>Weeks</u>	
ANTECEDENT CAUSE (B) <u>Generalized arteriosclerosis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>coronary arteriosclerosis on the left side</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>carcinoma of the prostate</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on <u>12-30, 1955</u> and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Samuel S. Kuegar</u>		M. D. <u>MD. Rainier MD</u>		DATE SIGNED <u>12/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/3/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		LOCATION (City, town, or county) (State) <u>D.C. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/30/55</u>		REGISTRAR'S SIGNATURE <u>Amanda Downey</u>		24. FUNERAL DIRECTOR <u>John S. Stewart</u>		ADDRESS <u>30-H. H. N.E.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 4 1956

RECEIVED

12295

CERTIFICATE OF DEATH

Reg. Dist. No. 243

I. PLACE OF DEATH:

COUNTY Prince Georges MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town)
 TOWN Glenn Dale (rural) LENGTH OF STAY (in this place) 2 mos., & 6 days.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE D. C. COUNTY -
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington 47X-3
 STREET ADDRESS (If rural give location) 918 H. St., N. W.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

4. DATE OF DEATH:

(Month)

(Day)

(Year)

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/26, 1955, to 12/2, 1955, that I last saw the deceasedalive on 12/2, 1955, and that death occurred at 1055 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

Glenn Dale Hospital

12/2/55

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 9 1955

RECEIVED

12252

CERTIFICATE OF DEATH

Reg. Dist. No. 259

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince Georges</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR		TOWN	
38 TOWN <i>Chesley</i>		24 days		TOWN <i>East Riverdale</i>		25	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Prince Georges General Hospital</i>				STREET ADDRESS (If rural give location) <i>6807 Zucada Road</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
GOLDIE HENNER				DEATH: 12/11/1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	Married	2-22-1901	54 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Maryland		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Hewitt Sharkey				Annie Crathree			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
9						Statistic Card	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Carcinoma breast</i>						4 months	
ANTECEDENT CAUSE (B) <i>Adeno carcinoma uterus</i>						5 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-6-1955 to 12-10-1955, that I last saw the deceased alive on 12-10-1955, and that death occurred at 12:35 PM, from the causes and on the date stated above.							
SIGNATURE <i>John P. Clum</i>				ADDRESS <i>Hyattsville 2</i>		DATE SIGNED <i>12-10-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		Dec 14, 1955		Fort Lincoln Cemetery		Colmar Manor, Maryland.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
12/12/55		<i>Manda Dorney</i>		F. Gasch's Sons Hyattsville, Md.			

MARGIN RESERVED FOR BINDING

RECEIVED

DEC 16 1955

BUREAU V.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12244

12296 CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY PRINCE GEORGES COUNTY		MARYLAND		STATE MARYLAND		COUNTY PRINCE GEORGES	
CITY (If outside corporate limits, write RURAL OR and give nearest town) OXON HILL, MARYLAND		LENGTH OF STAY (in this place) YEARS		CITY (If outside corporate limits, write RURAL and give nearest town) OXON HILL, MARYLAND- GLASS MANOR			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 217-AUDDREY LANE, OXON HILL, MD.				STREET ADDRESS APT. 402		(If rural give location)	
				217-AUDREY LANE, OXON HILL, MARYLAND			
3. NAME OF DECEASED (Type or Print) MARY J. HICKEY				4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 15th 1955			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH OCT. 30, 1866	9. AGE last birthday 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME MAKER		11. BIRTHPLACE (State or foreign country) GRANVILLE, MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL SULLIVAN				14. MOTHER'S MAIDEN NAME MARGARET HERLIHY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS OXON HILL, MD. MR. JOHN L. HICKEY (SON) 217-AUDREY LANE			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <i>Cerebro-vascular accident</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arterio-sclerosis - generalized</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1953, to Dec 15, 1955, that I last saw the deceased alive on Dec 14, 1955, and that death occurred at 12:25 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Robert W. Thompson</i>		ADDRESS (Street, city, town, state) <i>1300-N. St. Wash. D.C.</i>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 12/16/55		NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		LOCATION (City, town, or county) (State) SPRINGFIELD, MASSACHUSETTS	
24. REC'D BY REGISTRAR DATE <i>Dec 16-55</i>		REGISTRAR'S SIGNATURE <i>Edna F. Gellum</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Martin W. Thompson Co.</i>			

1955 CERTIFICATE OF DEATH

Part First No.

1. Name of deceased (Print or write full name)

2. Sex (M or F) and date of birth (Month, day, year)

3. Usual residence (Street, city, state, and zip)

4. Date of death (Month, day, year)

5. Place of death (City, state, and zip)

6. Cause of death (List all causes, beginning with the immediate cause)

7. Manner of death (Natural, accident, suicide, homicide, or undetermined)

8. Signature of physician (Print name and sign)

9. Signature of registrar (Print name and sign)

10. Signature of informant (Print name and sign)

11. Signature of medical examiner (Print name and sign)

12. Signature of coroner (Print name and sign)

13. Signature of funeral director (Print name and sign)

14. Signature of health officer (Print name and sign)

15. Signature of registrar (Print name and sign)

16. Signature of informant (Print name and sign)

17. Signature of medical examiner (Print name and sign)

18. Signature of coroner (Print name and sign)

19. Signature of funeral director (Print name and sign)

20. Signature of health officer (Print name and sign)

21. Signature of registrar (Print name and sign)

22. Signature of informant (Print name and sign)

23. Signature of medical examiner (Print name and sign)

24. Signature of coroner (Print name and sign)

25. Signature of funeral director (Print name and sign)

26. Signature of health officer (Print name and sign)

27. Signature of registrar (Print name and sign)

28. Signature of informant (Print name and sign)

29. Signature of medical examiner (Print name and sign)

30. Signature of coroner (Print name and sign)

1. Name of deceased (Print or write full name)

2. Sex (M or F) and date of birth (Month, day, year)

3. Usual residence (Street, city, state, and zip)

4. Date of death (Month, day, year)

5. Place of death (City, state, and zip)

6. Cause of death (List all causes, beginning with the immediate cause)

7. Manner of death (Natural, accident, suicide, homicide, or undetermined)

8. Signature of physician (Print name and sign)

9. Signature of registrar (Print name and sign)

10. Signature of informant (Print name and sign)

11. Signature of medical examiner (Print name and sign)

12. Signature of coroner (Print name and sign)

13. Signature of funeral director (Print name and sign)

14. Signature of health officer (Print name and sign)

15. Signature of registrar (Print name and sign)

16. Signature of informant (Print name and sign)

17. Signature of medical examiner (Print name and sign)

18. Signature of coroner (Print name and sign)

19. Signature of funeral director (Print name and sign)

20. Signature of health officer (Print name and sign)

21. Signature of registrar (Print name and sign)

22. Signature of informant (Print name and sign)

23. Signature of medical examiner (Print name and sign)

24. Signature of coroner (Print name and sign)

25. Signature of funeral director (Print name and sign)

26. Signature of health officer (Print name and sign)

27. Signature of registrar (Print name and sign)

28. Signature of informant (Print name and sign)

29. Signature of medical examiner (Print name and sign)

30. Signature of coroner (Print name and sign)

RECEIVED

BUREAU V. 2

DEC 27 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correctly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12253

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12245

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 245

1. PLACE OF DEATH:

COUNTY

Prince Georges

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN

Riverdale

LENGTH OF STAY
(In this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Seland Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md

COUNTY

Prince Georges

CITY (If outside corporate limits write RURAL and give nearest town)

OR
TOWN

Riverdale

STREET
ADDRESS

4403 Queensbury Road

3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

Edith Hermione Hislop

4. DATE

(Month)

(Day)

(Year)

OF
DEATH

12-30-

1955

5. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Female

White

Married

4-6-11

44 yrs.

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Secretary

M. G. M. - Motion Picture

Canada

Great Britain

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN
ONSET AND DEATH954X
Immediate cause

(a).....

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b).....

DUE TO

(c).....

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg, etc.) INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

12-29-55

M.

During operation for carcinoma of cervix

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John J. Maloney (Hyattsville, Md)

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

M. D. ASSISTANT MEDICAL EXAM.

12-30-55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 2, 1956

Mrs Jas. Severe

F Buscha sons Hyattsville, Md

RECEIVED

JAN 5 1956

BUREAU V. S.

12297

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince Georges</u> MARYLAND	CITY (If outside corporate limits, write RURAL or give nearest town) <u>Alms House - 6501 Daxcey Rd</u>	STATE <u>Maryland</u> COUNTY <u>Pr. Geo. Co.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>
TOWN <u>Alms House - 6501 Daxcey Rd</u>	HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6501 Daxcey Road S.E. Washington 28 DC</u>	TOWN <u>Seat Pleasant Pr Georges Co. Md</u>	STREET ADDRESS (If rural give location) <u>6310 Foote Street</u>
3. NAME OF DECEASED: (Type or Print) <u>Charles Henry Moran</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec 4, 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Dec 15, 1876</u>
9. AGE last birthday: <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Railway Express Co</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Washington DC</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A</u>	
13. FATHER'S NAME: <u>Henry Moran</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Bales</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service): <u>—</u>		16. SOCIAL SECURITY No. <u>705-01-6186</u>	
17. INFORMANT & ADDRESS: <u>Mrs Elroy Plant Lanham, Md</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
151X IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>		<u>1 hour.</u>	
ANTECEDENT CAUSE (S) (B) <u>Carcinoma of stomach</u>		<u>2 mo.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>General Arteriosclerosis</u>		<u>unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>			
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Natural Causes</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>—</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>—</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>Nov 8, 1955</u> to <u>Dec 4, 1955</u> , that I last saw the deceased alive on <u>Dec 3, 1955</u> , and that death occurred at <u>5¹⁰ A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Samuel Evan Watts</u>		DATE SIGNED <u>Dec 4/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>MT Olivet</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 5 1955</u>		REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	
24. FUNERAL DIRECTOR <u>Gasche Sons Hyattsville, Md</u>		ADDRESS <u>—</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

DEC 12 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
12278 2411 N. Charles Street, Baltimore
CERTIFICATE OF DEATH

12297

Reg. Dist. No. 245

1. PLACE OF DEATH: COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>PRINCE GEORGES</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HYATTSVILLE (LEWISDALE)</u> 15				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HYATTSVILLE (LEWISDALE)</u> 15			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2016 AVALON PLACE</u>				STREET ADDRESS (If rural, give location) <u>2016 AVALON PLACE</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>EMER</u>		(Middle) <u>WESTCOTT</u>		(Last) <u>IRONS</u>	
6. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Nov 8, 1891</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FREE AIRPLANE PARTS</u>		9. AGE last birthday <u>64</u> yrs.		4. DATE OF DEATH <u>DEC. 7</u> 19 <u>55</u>	
11. BIRTHPLACE (State or foreign country) <u>ROME, N.Y.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN EMER IRONS</u>				14. MOTHER'S MAIDEN NAME <u>NORA WESTCOTT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY No. <u>218-34-6096</u>		17. INFORMANT <u>Daniel R. Chen</u>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>260X</u> (a) <u>CORONARY THROMBOSIS</u>	<u>4 Hours</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>DIABETES MELLITUS</u>	<u>2 YEARS</u>
(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>12/7/55</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12/7, 1955, to 12/7, 1955, that I last saw the deceased alive on 12/7, 1955, and that death occurred at 9:05 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>Dec 10 1955</u>		<u>George Washington</u>		<u>Hyattsville - Prince Georges Co.</u>		<u>MD.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>Dec 7 1955</u>		<u>Mrs. Jas. Severance White</u>		<u>2901-14 St. N.W.</u>		<u>Washington, D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 12 1955

RECEIVED

12254

12249

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 245

1. PLACE OF DEATH:

COUNTY Prince Georges MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) 25 Riverdale LENGTH OF STAY (In this place) D.O.A.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 97 Island Memorial Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Pr. Geo
CITY (If outside corporate limits write RURAL and give nearest town) 14 College Park.
TOWN 14
STREET ADDRESS (If rural, give location) 6906-Dartmouth Ave

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print) William H. Wood Komp

4. DATE OF DEATH

(Month)

(Day)

(Year)

12-7-1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

Male
White
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Scientist

10b. KIND OF BUSINESS OR INDUSTRY:
U.S. Govt.

11. BIRTHPLACE (State or foreign country):
Japan

12. CITIZEN OF WHAT COUNTRY?
U.S.G.

13. FATHER'S NAME:

Fredrick Komp

14. MOTHER'S MAIDEN NAME:

Carrie Wood.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Wife - Same address.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

970.2
Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 12-7-55-3:00 P.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

Overdose of barbiturate

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John J. Maloney (Hyattsville Md)

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED

DEPUTY MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAM. ☐ 12-8-55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

12-9-1955

Mrs. Jas. Severel

F. Gasch's Sons Hyattsville, Maryland.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

DEC 12 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

12215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>PRINCE GEORGE</u> MARYLAND				STATE <u>(D.C.)</u> COUNTY <u>P. Geo.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>15 WYATTSVILLE</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>99 PAINT BRANCH NURSING HOME</u>				STREET ADDRESS (If rural, give location) <u>3420 FAIR Hill DR.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>LENA KIRKLEY KING</u>				<u>DEC 29 1955</u>			
5. SEX: <u>FEMALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>OCT 11, 1975</u>	
9. AGE last birthday: <u>80</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country): <u>S. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME: <u>DANIEL KIRKLEY</u>		14. MOTHER'S MAIDEN NAME: <u>BOUVETTE SMITH</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u>	
16. SOCIAL SECURITY No.: <u>NONE</u>		17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
Immediate cause (a) <u>cerebrovascular accident</u>				<u>24 days</u>			
Antecedent cause(s) (b) <u>hypertension</u>				<u>indefinite</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>Coronary thrombosis</u>							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)			
SUICIDE				(CITY OR TOWN)			
HOMICIDE				(COUNTY)			
(STATE)							
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>12-28, 1955</u> , to <u>12-29, 1955</u> , that I last saw the deceased alive on <u>12-29, 1955</u> , and that death occurred at <u>4:45 p.m.</u> , from the causes and on the date stated above.							
SIGNATURE				(DEGREE OR TITLE) ADDRESS			
<u>Edmund L. Burnett M.D.</u>				<u>7701 Carroll Ave. Takoma Park, Md.</u>			
DATE SIGNED <u>12-29-55</u>							
23. BURIAL, CREMATION REMOVAL (Specify): <u>TRANSFORMATION</u>				DATE THEREOF <u>Dec 30, 1955</u>			
NAME OF CEMETERY OR CREMATORY				LOCATION (City, town, or county) (State)			
<u>CHARLESTON</u>				<u>S. C.</u>			
24. FUNERAL DIRECTOR				ADDRESS			
<u>Mr. J. S. Hiner</u>				<u>Co 2901 14th St N.W. D.C.</u>			
REG. <u>Dec 29 1955</u>				RECEIVED BY LOCAL REGISTRAR'S SIGNATURE <u>Deputy -</u>			

MARGIN RESERVED FOR BINDING

RECEIVED

JAN 2 1966

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12208

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12248

Reg. Dist.

No. 242

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>District of Columbia</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN <u>Washington</u> <u>47X-3</u>	
TOWN <u>Largo</u>		<u>Permanent</u>		STREET ADDRESS (If rural, give location)		<u>742 Ridge Road SE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Central Avenue</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Raphael Carroll Knott</u>				<u>Dec 31 1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Single</u>		<u>Dec 22, 1935</u>	
9. AGE last birthday:		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>20</u> yrs.		Months Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Freshman Helper</u>				<u>Painting</u>		<u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME:			
<u>U.S.A.</u>				<u>Adrian Knott</u>			
14. MOTHER'S MAIDEN NAME:				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
<u>Elizabeth Carroll</u>				<u>No</u>			
16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS:			
				<u>Patricia Knott, same address</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Hemorrhage and shock</u> DUE TO Antecedent cause(s) (b) <u>Fracture skull, crushed chest and abdomen</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>fractured pelvis and left femur</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY:		21c. (City or town) (County) (State)			
<input type="checkbox"/>		<u>Central Ave</u>		<u>Largo P.S. 16</u>		<u>DC</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY:		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>12 31 55 3 PM</u>		<input checked="" type="checkbox"/>		<u>Struck by car</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE				DATE SIGNED			
<u>James D. Boyd</u>				<u>12-31-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>1/3/56</u>		<u>Cedar Hill</u>	
DATE REC'D BY LOCAL REG.				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>12/31/55</u>				<u>Carrie Campbell</u>		<u>Robert A. Mattingly</u>	
						<u>131-11 St. N. Wash. D.C. 48 E.</u>	

BUREAU V. 3

JAN 5 1956

RECEIVED

12255

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH:

COUNTY Prince Georges MARYLANDCITY (If outside corporate limits, write RURAL and give nearest town) Cheverly TOWN 3 HRS LENGTH OF STAY (in this place)HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince Georges

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY Prince GeorgesCITY (If outside corporate limits, write RURAL and give nearest town) Hyattsville TOWN 15STREET ADDRESS (If rural give location) 5711 Reed Street

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

CLARENCELANCASTER

4. DATE (Month)

(Day)

(Year)

OF DEATH:

12/51955

5. SEX:

6. COLOR OR RACE:

7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MCS11-8-541 yrs.

Months

Days

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

NONENONEMarylandU.S.A

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Clarence Lancaster Sr.Juanita Douglas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

4Hospital Record

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE

(A) Dehydration and Acidosis12L

ANTECEDENT CAUSE (B)

DUE TO

Bronchiopneumonia and3 day

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO

Diarrhea3 day

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-3, 1955, to 12-3, 1955, that I last saw the deceased alive on 12-3, 1954, and that death occurred at 7:54 A.M., from the causes and on the date stated above.

SIGNATURE

John W. PulcinM. D. 5301 Hamlet St. Hyattsville, Md. DATE SIGNED 12/5/55

23. BURIAL CREMATION, (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial12/7/55Carter MemorialPrince Geo. Co. Md.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

12/5/55Amanda DowneyA.S. Washington & Son 467 N. St. N.W.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 7 1955

RECEIVED

12251
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 245

Reg. Dist.

1. PLACE OF DEATH:

COUNTY Prince Georges MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) Hyattsville LENGTH OF STAY (in this place) transit
TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS B. & O. R. R. Tracks

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE md. COUNTY Pr. Geo.
CITY (If outside corporate limits write RURAL and give nearest town) Hyattsville
TOWN
STREET ADDRESS (If rural, give location) 4508 Emerson St.

3. NAME OF DECEASED:

(First) (Middle) (Last)

Ronald Carlton Lawson

4. DATE OF DEATH (Month) (Day) (Year)
Dec 19 1955

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Single

8. DATE OF BIRTH:

June 19 1943

9. AGE last birthday:

12 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.

10a. Usual OCCUPATION (Give kind of work done during most of work life, even if retired):

School

10b. KIND OF BUSINESS OR INDUSTRY:

School

11. BIRTHPLACE (State or foreign country):

MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Albert R. Lawson

14. MOTHER'S MAIDEN NAME:

Helen S. Kover

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

—

17. INFORMANT & ADDRESS:

Mother

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY R.R. Tracks)

21c. (City or town) (County) (State)

Hyattsville - Pr. Geo. md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 12-19-55 8:20 A.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

Struck by R.R. Train while crossing tracks

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John J. Maloney (Hyattsville Md.)

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.

DATE SIGNED

12-19-55

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

12-21-55

NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

LOCATION (City, town, or county) (State)

Hyattsville, Pr. Geo. md.

DATE REC'D BY LOCAL REG.

Dec 21 1955

REGISTRAR'S SIGNATURE

Mrs. Jas. Severe

24. FUNERAL DIRECTOR

E. J. J. J. J. J.

ADDRESS

Hyattsville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

DEC 28 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12256

Item 6, Film 191 1-11-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12252

231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince Georges</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Prince Geo.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>38 Chevy, Md.</i>		LENGTH OF STAY (in this place) <i>24 hrs.</i>		CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Switland, Md.</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>77 Prince Georges Gen. Hosp.</i>				STREET ADDRESS (If rural give location) <i>4690 Homer Ave.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>YOKE TANG Lee</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>Dec. 28, 19 55</i>			
5. SEX: <i>m</i>		6. COLOR OR RACE: <i>Y/O</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>married</i>		8. DATE OF BIRTH: <i>2/19/11</i>	
9. AGE last birthday <i>44</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>China Sea</i>		11. BIRTHPLACE (State or foreign country): <i>China</i>		12. CITIZEN OF WHAT COUNTRY? <i>Unknown</i>	
13. FATHER'S NAME: <i>Hong. Mow Lee</i>				14. MOTHER'S MAIDEN NAME: <i>Wong C.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT & ADDRESS: <i>Geo Lee 709 H St NW</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>526X Bronchiectasis, acute</i>						<i>48 hrs</i>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/28</i> , 19 <i>55</i> , to <i>12/29</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12/29</i> , 19 <i>55</i> , and that death occurred at <i>10:45 P.</i> M. from the causes and on the date stated above.							
SIGNATURE <i>Samuel J. Morgan</i>		M. D. <i>Mr. Rainier</i>		DATE SIGNED <i>12/29/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12/4/55</i>		NAME OF CEMETERY OR CREMATORY <i>Geo. Wash. Memo.</i>		LOCATION (City, town, or county) (State) <i>Prince Geo. Co. Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>12/30/55</i>		REGISTRAR'S SIGNATURE <i>Amanda Downey</i>		24. FUNERAL DIRECTOR <i>W.W. Chambers Co.</i>		ADDRESS <i>1400 Chapin St. N.W. Wash. D.C.</i>	

BUREAU V. S.

JAN 2 1956

RECEIVED

12257

12253

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Pt. Geo</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chesverly</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Seat Pleasant</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen. Hosp</u>				STREET ADDRESS (If rural, give location) <u>6310- Foote St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>James Albert Leinear</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12-19-1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>10-5-96</u>	
9. AGE last birthday: <u>59</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Salmon</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Automobile</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Cornelius Leinear</u>				14. MOTHER'S MAIDEN NAME: <u>Lillie Bryan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY No.: <u>214-03-8019</u>		17. INFORMANT & ADDRESS: <u>Mrs. Dorothy L. George - 9405- Orala St - Silver Springs Md</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>acute congestive heart failure</u>							
DUE TO							
Antecedent cause(s) (b) <u>Cardiovascular renal disease</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John J. Maloney (Hyattsville, Md)</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED <u>12-20-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Burtonsville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
DATE REC'D BY LOCAL REG. <u>12/21/55</u>		REGISTRAR'S SIGNATURE <u>Lemanda Downey</u>		24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 27 1955

BUREAU V. S.

12258

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u> MARYLAND				STATE <u>MD</u> COUNTY <u>P. H.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> OR TOWN				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> OR TOWN <u>23</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Hospital</u>				STREET ADDRESS (If rural give location) <u>9B. Ridge Rd.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Man</u> (First) <u>E</u> (Middle) <u>Long</u> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>12-10</u> 19 <u>55</u>			
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>10-14-77</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTH PLACE (State or foreign country): <u>Miss</u>	
13. FATHER'S NAME: <u>Calvin Griffin</u>				14. MOTHER'S MAIDEN NAME: <u>Mary West</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Martha & Keith Daughlin</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Generalized Carcinomatous</u>						months?	
ANTECEDENT CAUSE (B) <u>As the region unknown</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>11/20/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Generalized Carcinomatous</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/20</u> , 19 <u>55</u> , to <u>12/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/10</u> , 19 <u>55</u> , and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Samuel Mathias MD</u>		M.D. <u>1726 Eye St. NW</u>		ADDRESS <u>Uniontown Ala</u>		DATE SIGNED <u>12/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 13-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Mount</u>		LOCATION (City, town, of county) (State) <u>Uniontown Ala</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 10-55</u>		REGISTRAR'S SIGNATURE <u>Aracanda Downey</u>		24. FUNERAL DIRECTOR <u>L. M. Jones Co.</u>		ADDRESS <u>Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12/13/55

BUREAU V. S.

DEC 15 1955

RECEIVED

12299

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Prince Georges

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN Glenn Dale (rural)

LENGTH OF STAY (in this place)

6 yrs., 10 mos. & 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE D. C. COUNTY -

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Washington

47X-3

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Glenn Dale Hospital

(If rural, give location)

STREET ADDRESS

1275 Holbrook Terrace, N. E. ✓

3. NAME OF DECEASED: (Type or Print)

(First)

MARGARET

(Middle)

A

(Last)

Lynch

4. DATE OF DEATH:

(Month)

12

(Day)

6

(Year)

1955

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

Married

8. DATE OF BIRTH:

3/7/1893

9. AGE last birthday:

62 yrs.

IF UNDER 1 YEAR

Months

8

IF UNDER 24 HRS.

Days

29

Hours

-

Min.

-

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

-

11. BIRTHPLACE (State or foreign country):

Charles Co., Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

Thomas Vernon

14. MOTHER'S MAIDEN NAME:

Nettie Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

-

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

Decedent

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) DUE TO

Cor Pulmonale

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

2 yrs

7 yrs 3 mo.

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/17, 1949, to 12/6, 1955, that I last saw the deceased alive on 12/6, 1955, and that death occurred at 9:50 A.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS Glenn Dale Hospital

DATE SIGNED

23. BURIAL, CREMATION, REINTERMENT (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or County) (State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

BUREAU V. S.

DEC 13 1955

RECEIVED

12217

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Prince Georges MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Hyattsville LENGTH OF STAY (in this place) 4 mo.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Point Branch Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Mash. COUNTY D.C.
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Mash. D.C. 47X-3
 STREET ADDRESS (If rural, give location)
 ADDRESS

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE

(Month)

(Day)

(Year)

(Type or Print)

Charles Sherman Mackintosh

OF DEATH:

Dec. 319 55

5. SEX:

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

Male

White

Widowed

Nov. 16, 1874

81 yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Fireman Fire dept.

District of Columbia

U.S.A.

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Nursing Home Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

Bronchopneumonia

DUE TO

Antecedent cause(s)

(b)

inanutition

DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

Hemorrhagic Cystitis

INTERVAL BETWEEN ONSET AND DEATH

2 days5 wks.5 wks.

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

Hypertensive Cardiovascular disease

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1, 1955, to Dec. 3, 1955, that I last saw the deceased alive on Dec. 3, 1955, and that death occurred at 6:55 p.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

Edmund L. Burnett, M.D. 7701 Carroll Ave. Takoma Park, Md. 12-19-55

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Dec 3, 1955 James Devey

Regis & Nash-741-11th St. S.E. Wash. D.C.

M. 919

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 6 1955

RECEIVED

Mr. J. Edgar Hoover
Director, Federal Bureau of Investigation
Washington, D. C.

Charles E. Mackintosh

John J. Mackintosh

Franklin D. Roosevelt

James A. Roosevelt

81

December 16, 1954

Dec. 3

22

12300

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12257
Reg. Dist. No. 242

1. PLACE OF DEATH: COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Hillside</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5607--N--Street, S.E.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Hillside</u> STREET ADDRESS (If rural, give location) <u>5607--N--Street, S.E.</u>	
--	--	--	--

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>EARL KENNETH MANES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 17th 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Jan. 11th, 1897</u>
9. AGE last birthday: <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country): <u>Mamouth Springs, Ark.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Dave Manes</u>		14. MOTHER'S MAIDEN NAME: <u>Anne Helem (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY No.: <u>489-12-3313</u>	
17. INFORMANT & ADDRESS: <u>Martha Jane Manes, 5607--N--St. S.E. Hillside, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Toxemia, sepsis</u> DUE TO Antecedent cause(s) (b) <u>Generalized carcinomatosis</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION: <u>Nov 25, 1955</u>		19b. MAJOR FINDING OF OPERATION: <u>generalized carcinomatosis</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		21. HOW DID INJURY OCCUR?	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	
21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.			
SIGNATURE <u>James D. Bond</u>		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. M. D. <u>12-17-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12-19-55</u>	
NAME OF CEMETERY OR CREMATORY <u>MARLIN TEXAS</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 18-55</u>		REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Co. 517--11th St. S.E.</u>		ADDRESS <u>Washington, D.C.</u>	

BUREAU V. S.

DEC 27 1985

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12258

12301 CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGES</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>BELTSVILLE</u> TOWN <u>BELTSVILLE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>PRINCE GEORGES</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>BELTSVILLE</u> TOWN <u>BELTSVILLE</u> STREET ADDRESS (If rural give location) <u>4420 GREENWOOD Rd</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARTHA E. MANTZ</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 22 1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG 21, 1893</u>
9. AGE last birthday <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WINTON K. COBEN HAUER</u>		14. MOTHER'S MAIDEN NAME <u>LEVINA STAPLES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>NEWTON B. MANTZ 4420 Greenwood Rd.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>General Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Unknown</u>
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/6</u> , 19 <u>55</u> , to <u>12/19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/19</u> , 19 <u>55</u> , and that death occurred at <u>12/19</u> , M, from the causes and on the date stated above.			
SIGNATURE <u>John T. Lyman</u>		ADDRESS (Street, city, town, state) <u>5440 Silver Hill Rd SE</u>	
DATE SIGNED <u>12/23/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>DEC. 24, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATL</u>		LOCATION (City, town, or county) (State) <u>Suitland, Md</u>	
24. REC'D BY REGISTRAR <u>John K. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John K. Smith</u>	
DATE <u>Dec 27, 1955</u>		ADDRESS <u>Sons Co. 300 4th St Washington, D.C.</u>	

CERTIFICATE OF DEATH

Name of Deceased Winton R. Gopher Haver		Sex Male	
Date of Birth March 10, 1913		Place of Birth Chicago, Ill.	
Date of Death Dec 28, 1955		Place of Death Baltimore, Md.	
Cause of Death Heart Disease		Manner of Death Natural	
Physician's Signature [Signature]		Medical Examiner's Signature [Signature]	
Hospital or Place of Death [Blank]		County [Blank]	

BUREAU V. 2

DEC 28 1955

RECEIVED

DEC 28 1955 Washington, D.C.

12259

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince George's</u> MARYLAND		CITY (If outside corporate limits, write RURAL, OR and give nearest town) <u>Chesley, Maryland</u>		STATE <u>Maryland</u> COUNTY <u>Prince George's</u>		CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <u>HUNTSVILLE Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George's Gen. Hosp.</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location) <u>7200 Sheriff Road</u>			
3. NAME OF DECEASED: (First) <u>William</u> (Middle) <u>Mose</u> (Last) <u>Mose</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec. 27, 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>9/16/90</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country): <u>Prince Geo. Co. Md</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Mose</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth M. Mungun</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Helen Mose 1723 54th Ave. Hillside Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Massive Gastrointestinal Hemorrhage</u>						<u>24h.</u>	
ANTECEDENT CAUSE (B) <u>Essential ulcer</u>						<u>2 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic heart disease.</u>						<u>3 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic heart disease.</u>						<u>3 yrs.</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
SIGNATURE <u>Samuel J. M. Sugar</u>		M. D. <u>Wm. R. Rimmer, Md</u>		DATE SIGNED <u>12/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Epithany Cemetery Forestville Md.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>12/28/55</u>		REGISTRAR'S SIGNATURE <u>Amanda Downey</u>		24. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>		ADDRESS <u>517 N. St. St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 2 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correctly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12260 Item 9, Film G191 1-19-56 et
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 231

Reg. Dist. 12260
 No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE Md		COUNTY Pr. Geo	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cheverly		LENGTH OF STAY (in this place) 20-0-0		CITY (If outside corporate limits write RURAL and give nearest town) Colmar Manor		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince Georges Gen. Hosp.				STREET ADDRESS 3612-41st Ave			
3. NAME OF DECEASED: (First) Margaret (Middle) Mary (Last) Mayola				4. DATE OF DEATH 12-25-1955			
5. SEX: Female		6. COLOR OF RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 7-11-1911	
9. AGE last birthday: 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): House-wif		11. BIRTHPLACE (State or foreign country): New York		12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME: Joseph Francis M. Carthy				14. MOTHER'S MAIDEN NAME: Margaret Elizabeth Flaherty			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY No.: —		17. INFORMANT & ADDRESS: Husband - Same address.	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) Hemorrhage & shock		DUE TO			
Antecedent cause(s) (b) Rupture of esophageal varix		DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Cirrhosis of liver					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
SIGNATURE John J. Maloney (Hyattsville Md)		CHIEF MEDICAL EXAMINER		DATE SIGNED 12-25-55	
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Dec 27, 1955		NAME OF CEMETERY OR CREMATORY Washington National	
LOCATION (City, town, or county) Suitland Md.		(State)			
DATE REC'D BY LOCAL REG. 12/27/55		REGISTRAR'S SIGNATURE Amanda D. Downey		24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Maryland	
ADDRESS					

BUREAU V. S.

DEC 29 1955

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12261

2302 CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince George's</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Forestville</u>		<u>1 Yearxx</u>		TOWN <u>Forestville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Box. 231-A. Marlboro Pike</u>				<u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>IDA S. MAYHEW</u>				<u>Dec. 5th 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>July 28th. 1868</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Domestic</u>		<u>Camp Springs, Maryland.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William F. Allen</u>				<u>Charlotte A. Pyles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>9</u>				<u>Mrs Pearl O. Moore</u> <u>Box. 231-A. Marlboro Pike, Maryland.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>24 hrs</u>	
<u>450.0</u> IMMEDIATE CAUSE (A) <u>Acute Congestive Cardiac</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Failure</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>General arteriosclerosis</u>						<u>unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-18, 1955</u>, to <u>12-5, 1955</u>, that I last saw the deceased alive on <u>Dec 5, 1955</u>, and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Paul P. Van Natta</u>				<u>28 Dec 12-5-55</u>			
ADDRESS (Street, city, town, state)				M.D.			
<u>Washington</u>				<u>28 Dec 12-5-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 7-55</u>		<u>Bells Methodist Cemetery</u>		<u>Camp Springs, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>DATE Dec. 5-55</u>		<u>Edna F. Collins</u>		<u>1661- Good Hope S.E. RD</u> <u>Washington 20, D.C.</u>			

— 200 —

CERTIFICATE OF DEATH

Reg. Dist. No.

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Pine</u> <u>Georgia</u> MARYLAND		STATE <u>Delaware</u> COUNTY <u>Essex</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cherley, Maryland</u>	LENGTH OF STAY (in this place) <u>1 day</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Seaford</u>	<u>46X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Georgia Pav. Hosp.</u>		STREET ADDRESS (If rural give location) <u>322 Pine St</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Addie</u> <u>HESTER</u> <u>McWilliam</u>		OF DEATH: <u>Dec. 19, 1955</u>	
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Dec. 31, 1893</u>
9. AGE last birthday <u>61</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if seasonal) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A</u>	
13. FATHER'S NAME: <u>James Byrd Triett</u>		14. MOTHER'S MAIDEN NAME: <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records - Cherley, Ind</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of lung -</u>			
ANTECEDENT CAUSE (S) DUE TO <u>cerebral metastasis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. <u>Diabetes Mellitus</u>			
19. DATE OF OPERATION: <u>1 Oct 55</u>			
19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>12/3, 1955</u> , to <u>12/19, 1955</u> , that I last saw the deceased alive on <u>12-18, 1955</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>College Park Rd</u> DATE SIGNED <u>12/19/55</u>	
M.D. <u>[Signature]</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 23, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Sharptown Cemetery</u>		LOCATION (City, town, or county) (State) <u>Sharptown, Ind</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/19/55</u>		REGISTRAR'S SIGNATURE <u>Amanda Dorney</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>7 Euclid Ave Hyattsville, Ind</u>	

RECEIVED

DEC 22 1955

BUREAU V. S.

12303 CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

COUNTY Prince Georges

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Glenn Dale (rural)

LENGTH OF STAY (in this place)

10 mos., & 23 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Glenn Dale Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE D. C.

COUNTY -

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Washington

STREET ADDRESS

1817 Vernon St., N. W.

3. NAME OF DECEASED:

(Type or Print)

VIRGINIA

(Middle)

P

(Last)

MORGAN

4. DATE OF DEATH:

(Month)

(Day)

(Year)

12 19 1955

5. SEX:

Female

6. COLOR OR RACE:

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Separated

8. DATE OF BIRTH:

Unknown

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

60 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

Unknown

11. BIRTHPLACE (State or foreign country):

Warrenton, Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

William Brooks

14. MOTHER'S MAIDEN NAME:

Mollie Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

-

16. SOCIAL SECURITY No.:

Unknown

17. INFORMANT & ADDRESS:

Decedent

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

3 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Arteriosclerotic and Hypertensive Heart Disease 5 yrs.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐Not While at Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 12/6, 1955, to 12/19, 1955, that I last saw the deceased

alive on 12/18, 1955, and that death occurred at 6:30 AM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

Glenn Dale Hospital

12/19/55

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

12/19/55

Moe Weiss

Hall Bros. 621 Fla. Ave., N.W.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 28 1955

RECEIVED

12262

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherley, Maryland</u>		STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Rainier</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen. Hosp.</u>		LENGTH OF STAY (in this place) <u>16 hrs.</u>		STREET ADDRESS (If rural give location) <u>3208 Otis St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Ruby FRANCES Moyers</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>Dec. 27, 1955</u>			
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Nov. 18, 1879</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Robert T. Murphy</u>				14. MOTHER'S MAIDEN NAME: <u>Kate Lindsay</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hospital Records, Cherley, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.0</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Coronary artery occlusion</u>						<u>18 hrs</u>	
(B) <u>Arteriosclerotic ht. disease</u>						<u>3 yrs</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0 -</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>27 Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/22</u> , 19 <u>55</u> , and that death occurred at <u>12:45 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>John Kehos</u>		M. D. <u>Cherley Md</u>		DATE SIGNED <u>12/28/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/30/55</u>		REGISTRAR'S SIGNATURE <u>Annada Downey</u>		24. FUNERAL DIRECTOR <u>F. Pascha</u>		ADDRESS <u>Sons Hyattville Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 2 1966

12263

CERTIFICATE OF DEATH

Reg. Dist. No. 245

I. PLACE OF DEATH:

COUNTY Prince George MARYLAND
 CITY (If outside corporate limits, write OR and give nearest town) Riversdale RURAL ☐ LENGTH OF STAY (in this place) 2 days
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Iceland Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Pr Geo
 CITY (If outside corporate limits, write RURAL and give nearest town) Laurel RFD #2 Box 133 X
 OR TOWN
 STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED:

(First) Bessie (Middle) ANDERSON (Last) MUNSON
 (Type or Print)

4. DATE (Month) (Day) (Year)
 OF DEATH: December 20 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: June 14, 1878

9. AGE last birthday: 77 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Hwf. Home

11. BIRTHPLACE (State or foreign country): OHIO

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME:

WILLIAM ANDERSON

14. MOTHER'S MAIDEN NAME:

FLORINDA E. WILLIAMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: No

17. INFORMANT & ADDRESS:

WILLIAM + GERALD MUNSON - SAME ADDRESS

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) cerebral hemorrhage
 DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) arteriosclerosis
 DUE TO

(c)

Interval Between Onset And Death

2 days

year.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify) none

PLACE (Home, farm, factory, street, office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 25, 1955, to Dec 20, 1955, that I last saw the deceased

alive on Dec 20, 1955, and that death occurred at 11:40 PM, from the causes and on the date stated above.

SIGNATURE

(Signature or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Dec 23 - 55 Mrs. Jas. Severel
28-55

402 Main St. Laurel Md 12/20/55
De Witt Davidson, Laurel Md
Safety

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 2 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12266

12304

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH- COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>PRINCE GEORGES</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL-UPPER</u> LENGTH OF STAY (In this place) <u>7 yrs.</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL-UPPER MARYBOROUGH</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MARYBOROUGH RT #1, Box 42</u>				STREET ADDRESS (If rural, give location) <u>RT #1, Box 42</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>MAMIE</u> (Middle) <u>FRANCIS</u> (Last) <u>NEWMAN</u>		4. DATE OF DEATH		(Month) <u>DEC.</u> (Day) <u>22</u> (Year) <u>1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APR 13, 1886</u>	9. AGE last birthday	If under 1 year Months <u>69</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		If under 24 hrs. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>PISCATAWAY, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM M. NEWMAN</u>				14. MOTHER'S MAIDEN NAME <u>CECELIA BUTLER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>		17. INFORMANT <u>HUSBAND - WILLIAM L. NEWMAN</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>443X</u> (a) <u>CEREBRAL THROMBOSIS</u>						<u>15 MINUTES</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>CEREBRAL THROMBOSIS, RT. HEMIPLEGIA</u>						<u>18 days</u>	
(c) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u>						<u>30 years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>NONE</u>							
19a. DATE OF OPERATION <u>NONE</u>		19b. MAJOR FINDINGS OF OPERATION <u>NONE</u>				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>NONE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>NONE</u>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>NONE</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>NONE</u>			
22. I hereby certify that I attended the deceased from <u>DEC. 15th, 1955</u> , to <u>DEC. 22, 1955</u> , that I last saw the deceased alive on <u>DEC. 17th, 1955</u> , and that death occurred at <u>1:00 P.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Arthur Shaver Jr. M.D.</u>				ADDRESS <u>Branch Ave. at Woodyard RD. Clinton Md. 12/22/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/24/55</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>		LOCATION (City, town, or county) (State) <u>Roxbury Md.</u>	
DATE REC'D BY LOCAL REG. <u>12/23/55</u>		REGISTRAR'S SIGNATURE <u>John L. Danner</u>		24. FUNERAL DIRECTOR <u>The Hunt Funeral Home</u>		ADDRESS <u>Waldorf Md.</u>	

BUREAU V. S.

DEC 29 1955

RECEIVED

Reg. Dist. No. 251

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) AT DECEASED:	
COUNTY Prince Georges	MARYLAND	STATE Maryland	COUNTY Prince Georges
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cheverly	LENGTH OF STAY (in this place) 2 days	CITY(If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Rainier	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince Georges Gen.Hosp.	STREET ADDRESS (If rural give location) 4421--29th Street,		
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH December 23, 1955	
(First) MARGARET (Middle) ELIZABETH (Last) NILES			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: May 2nd, 1875
9. AGE last birthday 80 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: At home	
11. BIRTHPLACE (State or foreign country): Hoosick Falls, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: George Brew		14. MOTHER'S MAIDEN NAME: Julia Carter	
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		16. SOCIAL SECURITY NO. 065-14-3134D	
17. INFORMANT & ADDRESS: Julia M.Breast, 4421--29th St. Mt.Rainier, Md.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE 450.0		6 days	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		3 weeks	
(A) Terminal Bronchopneumonia		years	
(B) Congestive Heart Failure			
(C) Arteriosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July, 1955, to Dec 23, 1955, that I last saw the deceased alive on Dec 22, 1955, and that death occurred at 1 A.M. from the causes and on the date stated above.			
SIGNATURE R. J. P. [Signature]		ADDRESS V432 Queens Chapel Rd. Hyattsville, Md.	
DATE SIGNED 12/23/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/27/1955	
NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery		LOCATION (City, town, or county) (State) Hoosick Falls, N.Y.	
DATE REC'D BY LOCAL REGISTRAR 12/24/55		REGISTRAR'S SIGNATURE Amanda Lounney	
24. FUNERAL DIRECTOR W.W.Chambers Co., Riverdale, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1955

BUREAU V. S.

INSTRUCTIONS

1 **24 hours** after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12210

CERTIFICATE OF DEATH

12268-30

Reg. Dist. No. 244

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY PRINCE GEORGE'S		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN COLLEGE PARK		LENGTH OF STAY (in this place) 3 weeks		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3120 POWDER MILL ROAD				STREET ADDRESS (If rural give location) 9507 SEMINOLE STREET			
3. NAME OF DECEASED (First) (Middle) (Last) KATHERINE AMANDA NORBECK				4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 18 19 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JUNE 5, 1874	9. AGE last birthday 81 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED HOMEMAKER OWN HOME		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN McNELLY				14. MOTHER'S MAIDEN NAME JANE MURPHY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MRS. A. MYRON COWELL, ASHTON, MARYLAND			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
181X IMMEDIATE CAUSE (A) Carcinoma of the bladder with local and distant metastases						6 mos	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None							
19a. DATE OF OPERATION November 1955		19b. MAJOR FINDINGS OF OPERATION Carcinoma of the bladder with spread to ureters				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from November 1954, to December 18, 1955, that I last saw the deceased alive on December 17, 1955, and that death occurred at 9:35 A.M. from the causes and on the date stated above.							
SIGNATURE Bennet A. Porter, M.D.				ADDRESS (Street, city, town, state) M.D. 9301 Colesville Rd., Silver Spring, Md.		DATE SIGNED Dec. 18, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF DEC. 21, 1955		NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		LOCATION (City, town, or county) (State) PRINCE GEORGE'S CO., MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE John D. Smith		25. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey		ADDRESS SILVER SPRING, MD.	
DATE 12/19/55							

3000

17 - 2 - 1971

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BUREAU V. S.

DEC 21 1965

RECEIVED

12265

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Pine</u> <u>Georgia</u> MARYLAND				STATE <u>Md.</u> COUNTY <u>Tr. Geo.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Chesley, Ind.</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>4322 Van Buren St.</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Georgia Jr. Hosp.</u>				STREET ADDRESS (If rural give location) <u>Univ. PK. Ind.</u> 1			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Lillian Olivia</u> <u>Oldenburg</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>Dec.</u> <u>29</u> 19 <u>55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>April 6, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Pro Geo County</u>		11. BIRTHPLACE (State or foreign country): <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>Jensen</u>				14. MOTHER'S MAIDEN NAME: <u>Kristine Hansen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>Grace Watkins University Park Ind.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						<u>3 days</u>	
ANTECEDENT CAUSE (B) <u>Cerebral Thrombosis</u>						<u>2 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>8</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/1, 1955</u> to <u>12/29, 1955</u> , that I last saw the deceased alive on <u>12/29, 1955</u> , and that death occurred at <u>2⁰⁰ PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William Donald Bureau</u>				ADDRESS <u>3503 Bay St. Mt. Rainier Md</u>		DATE SIGNED <u>12/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 3 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Corington National</u>		LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-31-55</u>		REGISTRAR'S SIGNATURE <u>Amanda Downey</u>		24. FUNERAL DIRECTOR <u>F Busch and Hyattsville, Md</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 5 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12305

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12271
Reg. Dist. No. 242

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince George's</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Prince George's</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Silver Hill</u>				CITY (If outside corporate limits write RURAL and give nearest town) <u>Silver Hill</u>			
TOWN <u>Silver Hill</u>				TOWN <u>Silver Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3810 Aberdeen Street</u>				STREET ADDRESS (If rural, give location) <u>3810 Aberdeen Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Martin Samuel Ort</u>				<u>11 28 19 55</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED:		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Married</u>		<u>Nov 24, 1902</u>	
9. AGE last birthday:		10. USUAL OCCUPATION (Give kind of work done during most of work life, or retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>53 yrs.</u>		<u>Electrician</u>		<u>Pennsylvania</u>		<u>U.S.A.</u>	
13. FATHER'S NAME: <u>Grant Ort</u>				14. MOTHER'S MAIDEN NAME: <u>Bessie Gault</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.:			
				17. INFORMANT & ADDRESS: <u>Rita Ort, same address</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>Immediate cause (a) <u>acute congestive heart failure</u></p> <p>Antecedent cause(s) (b) <u>Cardiovascular renal disease</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<p>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</p> <p>SIGNATURE <u>James D. V. Boyd</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-28-55</u></p> <p>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/></p>							
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec 31-55</u>		<u>Cedar Hill</u>		<u>Smithland Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Dec 28-55</u>		<u>Edward F. Gillius</u>		<u>Simmons Bros</u>		<u>1661-4th Hope Rd. S E Wash DC</u>	

BUREAU V. S.

JAN 5 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12273

12306 **CERTIFICATE OF DEATH**Reg. Dist. No. 242

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince Georges</u>		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Forestville</u>				TOWN <u>Forestville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Armstrong Lane</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>MATTIE</u>		(Middle) <u>D.</u>		(Last) <u>OWEN</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>March 19th, 1866</u>	
				9. AGE last birthday <u>89</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Petersburg, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thomas Marks</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Whitehorn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Claudia Bookhultz</u> <u>Armstrong Lane, Forestville, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Cardiac Arrest</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/55</u> , 19 <u>55</u> , to <u>12/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/16</u> , 19 <u>55</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>David Hernandez</u>				ADDRESS (Street, city, town, state) <u>2901 Fairview St. S.E.</u>			
				DATE SIGNED <u>12/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 27, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) <u>Suitland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edna F. Sullivan</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Bros.</u>		ADDRESS <u>1661 Good Hope Rd SE</u> <u>Washington DC</u>	
DATE <u>Dec. 24-55</u>							

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BUREAU V. S.

DEC 30 1955

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and the other 7000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

12272

12307 CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 242

1. PLACE OF DEATH- COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Prince Georges			
CITY (If outside corporate limits, write RURAL and give nearest town) Forestville				CITY (If outside corporate limits, write RURAL and give nearest town) Oxon Hill			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Marlboro Pike				STREET ADDRESS (If rural, give location) 1901 Owens Road			
3. NAME OF DECEASED (Type or Print)		(First) ELMER		(Middle) EUGENE		(Last) OWENS	
4. DATE OF DEATH		(Month) December		(Day) 5		(Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 18, 1900	9. AGE last birthday 55 yrs.	If under 1 year Months 5	If under 24 hrs. Days 5	Hours 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coin Machine Operator				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Henry Owens			
14. MOTHER'S MAIDEN NAME Harriet Hall				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No			
16. SOCIAL SECURITY NO. 578-30-8513				17. INFORMANT Sadie Dyer Owens, 1901 Owens Road, Oxon Hill, Md.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause 816X Shock							
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last						Universal burns of the body - 3rd degree	
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, office bldg., etc.) Forestville 16 P.S. Hwy			
TIME (Month) (Day) (Year) (Hour) OF INJURY 12 5 55 6				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
HOW DID INJURY OCCUR? Car struck another and turned over							
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .							
SIGNATURE JAMES I. BOYD, M.D.				DATE SIGNED 12-6-55			
23. BURIAL INFORMATION Burial				DATE THEREOF Dec 9, 1955			
NAME OF CEMETERY Saint Barnabas Cemetery				LOCATION (City, town, or county) (State) Oxon Hill, Maryland			
24. FUNERAL DIRECTOR W.W. CHAMBERS				ADDRESS 517 11th St., S.E. Wash. D.C.			

D.C.

BUREAU V. S.

DEC 12 1955

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12266

CERTIFICATE OF DEATH

Reg. Dist. No. 231

Item 7, Film 91 1-5-56 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince George's</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>		STATE <u>Maryland</u> COUNTY <u>Prince George's</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Oak, Md.</u>	
OR TOWN <u>Chesley, Md.</u>		LENGTH OF STAY (in this place) <u>22 days</u>		OR TOWN <u>Chapel Oak, Md.</u>		STREET ADDRESS (If rural give location) <u>5714 Rome Street</u>	
3. NAME OF DECEASED: (First) <u>Red</u> (Middle) <u>Palm</u> (Last) <u>Palmer</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>Dec. 28, 1955</u>			
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>E</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>?</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Nelson Palmer</u>				14. MOTHER'S MAIDEN NAME: <u>Erlene Moton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hospital records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
446X IMMEDIATE CAUSE (A) <u>Uremic</u>						<u>5 days</u>	
ANTECEDENT CAUSE (B) <u>Nephrosclerosis</u>						<u>2 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arteriosclerosis</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral arteriosclerosis</u>						<u>years</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>12-29-55</u>				NAME OF CEMETERY OR CREMATORY <u>Washington</u>		LOCATION (City, town, or county) (State) <u>D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/29/55</u>		REGISTRAR'S SIGNATURE <u>Amanda Dorney</u>		24. FUNERAL DIRECTOR <u>H.S. Washington & Sons</u>		ADDRESS <u>467 N St. N.W. Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12275

12267

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> TOWN <u>5 days</u>				STATE <u>Maryland</u> COUNTY <u>P. Geo.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Upper Marlboro</u> X STREET ADDRESS (If rural give location) <u>1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen. Hosp.</u>							
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Esther Elizebeth Phelps</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec 16 1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH: <u>7-9-1882</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Hgwf.</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>James Madison Carrick</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Elizebeth Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Esther Phelps Duvall Rt #2., Box 102, Upper Marlboro, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>							<u>5 days</u>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis</u>							<u>10 yrs</u>
19A. DATE OF OPERATION: <u>None</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 11, 1955</u> , to <u>Dec 16, 1955</u> , that I last saw the deceased alive on <u>Dec 16, 1955</u> , and that death occurred at <u>8:05 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James C. Kauer</u>				ADDRESS <u>Upper Marlboro, Md.</u> DATE SIGNED <u>12-16-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>December 20, '55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Oak Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mitchellville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/20/55</u>		REGISTRAR'S SIGNATURE <u>Amanda Downey</u>		24. FUNERAL DIRECTOR <u>Ritchie Bros.</u>		ADDRESS <u>Upper Marlboro, Md.</u>	

RECEIVED

DEC 22 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12276

12308

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH COUNTY <u>Pr. Geo's County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Pr. Geo's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>(NMI)</u> (Middle) <u>Phelps</u> (Last)		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>16</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 25, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	9. AGE last birthday <u>82</u> yrs.
13. FATHER'S NAME <u>Charles Phelps</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME <u>Woodward</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u>		17. INFORMANT <u>Helene Phelps Mitchellville, Maryland</u>	
16. SOCIAL SECURITY No.		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
334* Immediate cause (a) <u>Cerebral Arteriosclerosis</u>		<u>9 mos</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arteriosclerosis - generalized</u>		<u>Unk</u>	
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Metastatic Prostatic CARCINOMA</u>		<u>8 years</u>	
19a. DATE OF OPERATION <u>1949</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Prostate & Local metastases</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>47</u> , to <u>16 Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>14 Dec</u> , 19 <u>55</u> , and that death occurred at <u>2:00 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Dr. B. Sanner</u>		DATE SIGNED <u>16-12-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	
DATE REC'D BY LOCAL REG. <u>12-20-55</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
REGISTRAR'S SIGNATURE <u>Wm. A. G. Youngling</u>		24. FUNERAL DIRECTOR <u>Ritchie Bros. Upper Marlboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

James Brady
- SUN -

BUREAU V. S.

DEC 28 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12268

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12277
Reg. Dist.

No. 245

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write TOWN and give nearest town) <u>Riverdale</u>		LENGTH OF STAY (in this place) <u>6 hrs.</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Beltsville, Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Selma Memorial Hosp</u>				STREET ADDRESS (If rural, give location) <u>4905 Wisconsin Avenue</u>			
3. NAME OF DECEASED: (First) <u>Phillip</u> (Middle) <u>Sandley</u> (Last) <u>Pilkerton</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>24</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Mar</u>		8. DATE OF BIRTH: <u>11-15-1888</u>	
9. AGE last birthday: <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William Pilkerton</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Elizabeth Jarboe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>W.W.I</u>				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. John H. Flora - Same address.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Hemorrhage & shock</u>				INTERVAL BETWEEN ONSET AND DEATH			
DUE TO							
Antecedent cause(s) (b) <u>Subdural hemorrhage</u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture of 1st 5 ribs with contusion of lungs</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg, etc.) <u>street</u>		21c. (City or town) (County) (State) <u>Beltsville - Pr. Geo - Md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12-24-55 4:30 P.M.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Struck by auto. while crossing Boulevard</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>John J. Maloney - Hyattsville, Md</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> <u>12-25-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>				DATE THEREOF <u>12-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
DATE REC'D BY LOCAL REG. <u>Dec 27 1955</u>				REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>		24. FUNERAL DIRECTOR <u>W.W. Chambers & Co. Riverdale, Maryland</u>	

RECEIVED

DEC 29 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12278
12309 Item 7, Film 191 1-16-56 et
CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince George's</i> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <i>University Park</i>	STATE <i>Md.</i> COUNTY <i>Prince George's</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>University Park</i>
OR (and give nearest town) <i>University Park</i>	LENGTH OF STAY (in this place) <i>5 yrs</i>	STREET ADDRESS (If rural give location) <i>4003 Beechwood Rd</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED: (First) <i>RUTHERFORD</i> (Middle) <i>HAYES</i> (Last) <i>POMEROY</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>DEC. 29 1955</i>	
5. SEX: <i>m</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>Oct 5 1878</i>
9. AGE last birthday: <i>77</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Grocery</i>	
11. BIRTHPLACE (State or foreign country): <i>va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Jack H Pomeroy</i>		14. MOTHER'S MAIDEN NAME: <i>Leath</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <i>Mrs. Melcher - 4003 Beechwood Rd</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
154X IMMEDIATE CAUSE (A) <i>Carcinoma, Rectosigmoidal</i>		197.	
ANTECEDENT CAUSE (S): (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Atherosclerosis gen. Pericarditis, aortic aneurysm, abd. aorta</i>		172.	
19A. DATE OF OPERATION: <i>none</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan 1, 1955</i> , to <i>Dec 29 1955</i> , that I last saw the deceased alive on <i>Dec 29, 1955</i> , and that death occurred at <i>12:30 PM</i> , from the causes and on the date stated above.			
SIGNATURE <i>P. L. Jacob, M.D.</i>		ADDRESS <i>5420 Kanan Rd NW 1429/55</i>	
DATE SIGNED			
23. BURIAL CREMATION, REMOVAL (SPECIFY) <i>12/31/55</i>		NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN Cem.</i> LOCATION (City, town, or county) <i>Prince George's Co.</i> (State)	
DATE REC'D BY LOCAL REGISTRAR <i>Dec - 29 1955</i>		REGISTRAR'S SIGNATURE <i>Mrs. James Beresford</i>	
24. FUNERAL DIRECTOR <i>The S.H. Niles Co.</i>		ADDRESS <i>2901 14th St NW</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 2 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12218
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 245

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Prince Geo -</u>	
CITY (If outside corporate limits, write and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write and give nearest town)			
15 TOWN <u>Hyattsville</u>		<u>9 yrs</u>		OR TOWN <u>Hyattsville</u>		15	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5611- 35th Ave</u>				STREET ADDRESS (If rural, give location) <u>5611- 35th Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Walter Albert Powell</u>				<u>12-6-1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Wid</u>	8. DATE OF BIRTH: <u>3-13-95</u>	9. AGE last birthday: <u>60</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Steam Engineer Georgetown University</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Michigan</u>		11. BIRTHPLACE (State or foreign country): <u>Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.G.</u>							
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>577-05-7246</u>		17. INFORMANT & ADDRESS: <u>Walter Francis Powell. Landover Hills</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Acute congestive heart failure</u> DUE TO Antecedent cause(s) (b) <u>Coronary artery disease</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>							
SIGNATURE <u>John W. Maloney (Hyattsville, Md)</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-6-55</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>Dec. 18/1955</u>		NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN Cem.</u>		LOCATION (City, town, or county) (State) <u>COLMAR MANOR Rte 60, Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>Dec 7 1955</u>		REGISTRAR'S SIGNATURE <u>James Devery</u>		24. FUNERAL DIRECTOR <u>W. W. Chambers Co. - Riverdale, Md</u>		ADDRESS	

RECEIVED

DEC 9 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 See: Birth Cert. et

12280

12269 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince Georges</u> MARYLAND	CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>CHEDERTY</u>	STATE <u>md.</u> COUNTY <u>PRINCE GEORGES</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MT. RAINIER</u> 16
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Hospital</u>	LENGTH OF STAY (in this place) <u>1 HR. 5 min</u>	STREET ADDRESS (If rural give location) <u>4114 - 30th STREET</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>BABY BOY BEAMY</u>		<u>12 / 9 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>12/9/55</u>
9. AGE last birthday		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	
11. BIRTHPLACE (State or foreign country): <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Frederick Ralph Beamy</u>		14. MOTHER'S MAIDEN NAME: <u>MARY Fornittia Pyles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT'S ADDRESS:	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
742.5 IMMEDIATE CAUSE		(A) <u>Pulmonary anoxia</u> 1 Hour	
ANTECEDENT CAUSE (B)		(B) <u>Fetal atelectasis</u> 1 Hour	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>Prematurity</u> 6 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/9</u> 19 <u>55</u> , to <u>12/9</u> 19 <u>55</u> that I last saw the deceased alive on <u>12/9</u> 19 <u>55</u> , and that death occurred at <u>9:10 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Danney Sugar</u>		M. D. <u>Mr. Kerner</u> DATE SIGNED <u>12/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Cremation</u>		<u>Dec 16 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Prince Georges Gen Hosp Chederty</u>		<u>md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>12/13/55</u>		<u>Amanda Droney</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Sam W Beamy</u>		<u>Sgt.</u>	

BUREAU V. E.

DEC 15 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1812281

12219

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE Maryland		COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
15 TOWN Hyattsville		11 yrs.		15 TOWN Hyattsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3903 Queensbury Road				STREET ADDRESS (If rural give location) 3903 Queensbury Road			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
SUSANA FRANCES REDMILES				December 22 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
Female	White	Widowed	December 28/1867	87 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife		At home		Baltimore, Md.		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Francis Phillips				Appolina Adams			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
No		None		Miriam E. James, 3903 Queensbury Rd. Hyattsville, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.0 IMMEDIATE CAUSE				(A) Arteriosclerotic Heart Disease			
ANTECEDENT CAUSE (S)				(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. no							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
no				no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?			
no		M.					
22. I hereby certify that I attended the deceased from Jan 1, 1955, to Dec 22, 1955, that I last saw the deceased alive on Dec 21, 1955, and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Beene Bonnie M.D.				301-B-h E.B.B. 12/23/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12-27-55		Ft. Lincoln		Bladensburg Md	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
Dec 28, 1955		James J. Jerey		W.W. Chambers Company, Riverdale, Md.			

BUREAU V. S.

JEC 28 1955

RECEIVED

12270 CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince Georges</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Prince Georges</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>38 Cheverly</i>		LENGTH OF STAY (in this place) <i>7 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Colmar Manor</i> <i>x</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>177 Prince Georges General Hosp.</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (First) <i>Thomas</i> (Middle) (Last) <i>Redmond</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>12/21</i> 19 <i>55</i>			
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>5-2-87</i>	9. AGE last birthday: <i>68</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <i>Handyman</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY: <i>USA</i>	
13. FATHER'S NAME: <i>Thomas Redmond</i>				14. MOTHER'S MAIDEN NAME: <i>Catherine Shindler</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Statistic Card -</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <i>Myocardial compression</i>							
ANTECEDENT CAUSE (S) (B) <i>Cerebral edema</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Cerebral vascular accident</i>						5 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>Dec 19, 1955</i>		19B. MAJOR FINDINGS OF OPERATION: <i>no significant objective findings</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>19 Dec, 1955</i> to <i>20 Dec 19 55</i> that I last saw the deceased alive on <i>20 Dec, 1955</i> , and that death occurred at <i>4:21 A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>John P. Lord</i>		M. D. <i>Butterday</i>		ADDRESS <i>12/21/55</i>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12/24/55</i>		NAME OF CEMETERY OR CREMATORY <i>Evergreen</i>		LOCATION (City, town, or county) (State) <i>Bladensburg, Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>12/24/55</i>		REGISTRAR'S SIGNATURE <i>Amanda Dourney</i>		24. FUNERAL DIRECTOR <i>F. Gascoigne</i>		ADDRESS <i>Hyttonville Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1955

BUREAU V. S.

12271

12283

Reg. Dist.

No. 231

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince Georges</i>		MARYLAND		STATE <i>Va</i>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Arlington</i>			
TOWN <i>Cherry</i>		<i>2 weeks</i>		STREET ADDRESS (If rural, give location) <i>3906-N. Wash. Boulevard</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <i>Henry</i> (Middle) <i>Edison</i> (Last) <i>Richlong</i>				12-7-1955			
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>Married</i>	8. DATE OF BIRTH: <i>Aug 22-1903</i>	9. AGE last birthday: <i>52</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Iron Worker Construction</i>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>S. Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Henry E. Richlong</i>				14. MOTHER'S MAIDEN NAME: <i>Suzie Corwell Miller</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>9</i>		16. SOCIAL SECURITY No.: <i>579-01-4548</i>		17. INFORMANT & ADDRESS: <i>Wife - Same address</i>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
901.3 Immediate cause		(a) <i>Toxemia and exhaustion</i>			
Antecedent cause(s)		(b) <i>Septicemia</i>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) <i>Fracture of ribs, pelvis & skull</i>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <i>12-10-55</i>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>Bludge</i>)		21c. (City or town) (County) (State) <i>Brentwood-P. Geo. 16 Md.</i>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>11-22-55 10:30 M.</i>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Known from ladder to ground</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>					
SIGNATURE <i>John D. Maloney (Hyattsville, Md.)</i>		M. D. <i>CHIEF MEDICAL EXAMINER</i>		DATE SIGNED <i>12-7-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Removal</i>		DATE THEREOF <i>12-10-55</i>		NAME OF CEMETERY OR CREMATORY <i>London Park</i>	
DATE REC'D BY LOCAL REG. <i>12/7/55</i>		REGISTRAR'S SIGNATURE <i>Wanda D. Doney</i>		24. FUNERAL DIRECTOR <i>W.K. Hunterman & Son</i>	
				ADDRESS <i>5732 N. Ave. N. Ave. Wash. D.C.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 9 1955

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12310 CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH- COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>PRINCE GEORGE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>MITCHELLSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>MITCHELLSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>556 ENTERPRISE RD</u>		STREET ADDRESS (If rural, give location) <u>RT 556 ENTERPRISE Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Harry</u> <u>Rix</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec.</u> <u>27</u> <u>1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>NOV 8, 1877</u>
9. AGE last birthday <u>78</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>FEDERAL GOVT.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>		11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>UNKNOWN</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY No. <u>NONE</u>		17. INFORMANT <u>L.C. THOMPSON</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause <u>420.0</u> <u>Coronary Thrombosis with occlusion</u>		<u>acute</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(b) <u>Arteriosclerotic Hypertensive Heart Disease</u>		<u>year</u>
(c) <u>Generalized Atherosclerosis</u>		<u>year</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Emphysema</u>		
19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION <u>Emphysema</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>0</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>0</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>0</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>0</u>

22. I hereby certify that I attended the deceased from Oct, 1955, to Dec 27, 1955, that I last saw the deceased alive on 12/9, 1955, and that death occurred at 430 m., from the causes and on the date stated above.

SIGNATURE James Kurt MD (Degree or title) ADDRESS RFD Bowie Md DATE SIGNED 12/27/55

23. BURIAL CREMATION REMOVAL (Specify) Burial DATE THEREOF 12/30/55 NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery LOCATION (City, town, or county) (State) Arlington Va

DATE REC'D BY LOCAL REG. Dec. 29-55 REGISTRAR'S SIGNATURE Carrie Campbell 24. FUNERAL DIRECTOR W W Chambers ADDRESS 557-11 St Wash DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

No 2

Consulted with John T.
Maloney M. D. regarding
this case.

James K. Kuf

BUREAU V. B.

JAN 5 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 243

12311

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Prince Georges	MARYLAND	STATE D. C.	COUNTY -
CITY (If outside corporate limits, write OR and give nearest town) TOWN Glenn Dale (rural)	RURAL LENGTH OF STAY (in this place) 8 days	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	47X-3
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS (If rural give location) 5045 Sargeant Rd., N.E.	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) Jeter	(Middle) M.	(Last) Roberts	(Month) Dec. (Day) 10 (Year) 19 55
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 4/10/1898
9. AGE last birthday: 57 yrs.		10. MONTHS 8 DAYS 0 HRS. 0 MIN.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Carpenter		10b. KIND OF BUSINESS OR INDUSTRY: Self-employed	
11. BIRTHPLACE (State or foreign country): Marshall, N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Dolph Roberts		14. MOTHER'S MAIDEN NAME: Priscilla Dalton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO.: 577-05-3189	
17. INFORMANT & ADDRESS: Decedent		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause (a) Carcinoma of right kidney with pulmonary metastases		9 months	
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO			
(c)			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: 6/19/45		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/2, 1955, to 12/10, 1955, that I last saw the deceased alive on 12/10, 1955, and that death occurred at 4:50 A.M., from the causes and on the date stated above.			
SIGNATURE (Degree or title) Daniel Leo Amicane MD		DATE SIGNED 12/10/55	
ADDRESS Glenn Dale Hospital			
23. BURIAL, CREMATION, REMOVAL (Specify) burial		DATE THEREOF 12/13/55	
NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		LOCATION (City, town, or county) Arlington Va.	
DATE REC'D BY LOCAL REGISTRAR 12/10/55		REGISTRAR'S SIGNATURE Noel Wein	
24. FUNERAL DIRECTOR B.H. Limes Co.		ADDRESS 2961-14th St. N.W.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 20 1955

RECEIVED

12312

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12286
Reg. Dist. No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Prince Geo</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Palm Park</u>		<u>4 mos</u>		TOWN <u>Palm Park - Hyattsville</u>		<u>x</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7827 Munsey Road</u>				STREET ADDRESS (If rural, give location) <u>7828 Munsey Road</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Isabel</u>		(Middle)		(Last) <u>Rosenberg</u>		(Month) (Day) (Year) <u>12-12-1953</u>	
(Type or Print)							
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Wid</u>		8. DATE OF BIRTH: <u>9-15-63</u>	
						9. AGE last birthday: <u>92</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY:			
				11. BIRTHPLACE (State or foreign country): <u>Russia</u>			
13. FATHER'S NAME: <u>Israel Basin</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:			
				17. INFORMANT & ADDRESS: <u>Simon Rosenberg - Same address</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
904.0 Immediate cause		(a) <u>Exhaustion & Semblity</u>			
Antecedent cause(s)		DUE TO <u>Fracture of left hip</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		DUE TO <u>Fall in home</u>			
		(c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Serious heart disease</u>					
19a. DATE OF OPERATION: <u>11-1-55</u>		19b. MAJOR FINDING OF OPERATION: <u>Interthoracic aortic aneurysm</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Palm Park - Prince Geo - Md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9-26-55 7:00 PM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall in home</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>John J. Maloney (Hyattsville Md)</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-12-55</u>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>12/13/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Star of David</u>	
DATE REG'D BY LOCAL REG. <u>12/12/55</u>		REGISTRAR'S SIGNATURE: <u>Amanda Downey</u>		24. FUNERAL DIRECTOR: <u>Goldberg Funeral Home</u>	
				ADDRESS: <u>4217 9th St NW Wash DC</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

DEC 14 1955

RECEIVED

12272 CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince George</i>	MARYLAND	STATE <i>Md</i>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>X Riverdale</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>	<i>3001.4</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Beland Memorial Hosp</i>		STREET ADDRESS (If rural give location) <i>3305 Powhattan Ave</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>BERNARD M. SACHS</i>		DATE OF DEATH: <i>12-15-1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <i>July 26, 1909</i>
		9. AGE last birthday <i>46</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life. If retired)		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<i>Merchant</i>		<i>Soft Drinks</i>	<i>Baltimore Md</i>
12. CITIZEN OF WHAT COUNTRY: <i>U.S.</i>			
13. FATHER'S NAME: <i>Robert Sachs</i>		14. MOTHER'S MAIDEN NAME: <i>Annie</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <i>Rose L. Sachs - Same</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>420.1</i>			
ANTECEDENT CAUSE (B) <i>Recurrent attacks of coronary thrombosis with myocardial infarction due to arteriosclerosis</i>			<i>12 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Apr</i> , 1943 to <i>Dec 15</i> , 1955 that I last saw the deceased alive on <i>Dec. 10</i> , 1955, and that death occurred at <i>10:50 P</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Meon B. Kuhl m</i>		ADDRESS <i>M. D. 2320 Eutaw Pl</i>	
DATE SIGNED <i>12/15/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>12-18-1955</i>	NAME OF CEMETERY OR CREMATORY <i>BETH TFILOH</i>	LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>
DATE REC'D BY LOCAL REGISTRAR <i>DEC 18 1955</i>		24. FUNERAL DIRECTOR ADDRESS <i>Leuris Inc - 2100 Eutaw Pl</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*Dr Maloney or my confidential
assistant*

RECEIVED

DEC 21 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12288

ITEM 8

See B.C. 1/5/54 P.B.C. 12273 CERTIFICATE OF DEATH

Reg. Dist. No. 142

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Cheverly</u>		<u>9 1/2 hours</u>		<u>Mitchellville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges General Hospital</u>				STREET ADDRESS (If rural give location) <u>Route #1, Box 68</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Robert Savoy</u>				OF DEATH: <u>12-24</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Negro</u>	<u>Single</u>	<u>1-5-56</u>	<u>1</u> yrs.	<u>11</u> Months	<u>11</u> Days	<u>11</u> Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles Savoy</u>				<u>Frances Shorter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<u>Statistic Card</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						<u>24 hrs.</u>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Right hydronephrosis & hydronephrosis</u>						<u>2 yrs.</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/23</u> , 19 <u>55</u> , to <u>12/24</u> , 19 <u>55</u> that I last saw the deceased alive on <u>12/24</u> , 19 <u>55</u> , and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>William R. Schmitz</u>		<u>M.D. 7220 East Rd.</u>		<u>Dec. 24 55</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>12-27-55</u>		<u>Woodlawn</u>		<u>Bermary Rd.</u>		<u>D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Dec. 25-55</u>		<u>Karne Campbell</u>		<u>Harry S. Washington & Sons</u>		<u>467 N. 1st St.</u>	

BUREAU V. S.

DEC 30 1955

RECEIVED

12313

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>15</u> TOWN <u>West Hyattsville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>15</u> <u>West Hyattsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7957--18th Avenue</u>				STREET ADDRESS (If rural give location) <u>7957--18th Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>VIRGIL KATHERINE SHOCKLEY</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec. 30th, 19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 6/ 1917</u>	9. AGE last birthday <u>38</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>At home</u>		11. BIRTHPLACE (State or foreign country): <u>Ravalli, Montana</u>	
13. FATHER'S NAME: <u>John E. Broom</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> <u>Bone</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Anna Jordan</u>	
18. MEDICAL CERTIFICATION				17. INFORMANT & ADDRESS: <u>C. Wilfred Shockley 7957--18th Ave. West Hyattsville Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE <u>170x</u>				<u>one hour</u>			
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>5 mos</u>			
(A) <u>Acute pulmonary failure</u>							
(B) <u>Metastatic carcinoma</u>							
(C) <u>Carcinoma of left breast</u>				<u>6 mos.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>July 23, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma left breast</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 1954</u> , to <u>Dec 30, 1955</u> , that I last saw the deceased alive on <u>Dec. 29, 1955</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James R. Coleman M.D.</u>				DATE SIGNED <u>12/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>1/4/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Lone Pine Cemetery</u>	
				LOCATION (City, town, or county) <u>Darby, Montana</u>		(State)	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 3 1956</u>				REGISTRAR'S SIGNATURE <u>James Sevey</u>		24. FUNERAL DIRECTOR ADDRESS <u>W.W. Chambers Company, Riverdale, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 5 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

-12314

Reg. Dist. 12290

No. 242

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits write RURAL OR and give nearest town) <u>District Heights</u>		LENGTH OF STAY (in this place) <u>1 year</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>District Heights</u>		OR TOWN <u>District Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2504 Addison Road</u>				STREET ADDRESS (If rural, give location) <u>2504 - Addison Road</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Norma</u>		(Middle) <u>Seagle</u>		(Last) <u>Simmons</u>		(Month) (Day) (Year) <u>Dec 11 1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>		8. DATE OF BIRTH: <u>Aug 19, 1921</u>	
9. AGE last birthday: <u>34</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, <u>Receptionist</u>)		10b. KIND OF BUSINESS OR INDUSTRY: <u>News</u>		11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>James Clarence Seagle</u>		14. MOTHER'S MAIDEN NAME: <u>Fala Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>229-12-2769</u>		17. INFORMANT & ADDRESS: <u>Harold B. Simmons, same address</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>Immediate cause (a) <u>Subarachnoid hemorrhage</u></p> <p>DUE TO</p> <p>Antecedent cause(s) (b) <u>Ruptured aneurysm of anterior cerebral artery</u></p> <p>DISEASES OR CONDITIONS, IF ANY, giving rise to the above cause stating underlying cause last (c)</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>Dec 13, 1955</u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
<p>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</p> <p>SIGNATURE <u>James D. B. B. B.</u> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-11-55</u></p> <p>M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/></p>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Dec 13, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State): <u>Suitland Maryland.</u>	
DATE REC'D BY LOCAL REG. <u>12/12/55</u>		REGISTRAR'S SIGNATURE: <u>Carrie Campbell</u>		24. FUNERAL DIRECTOR: <u>F. Gasch's Sons</u> ADDRESS: <u>Hyattsville, Maryland.</u>			

RECEIVED

DEC 19 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12274 CERTIFICATE OF DEATH

Reg. Dist. No. 231...

1. PLACE OF DEATH: (A)				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince Georges</i> MARYLAND				STATE <i>Md</i> COUNTY <i>P.G.</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>				CITY (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Prince Georges Hospital</i>				STREET ADDRESS (If rural give location) <i>4406 - 31st St.</i>			
3. NAME OF DECEASED: (First) <i>Simms</i> (Middle) <i>Mabel</i> (Last) <i>Simms</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>12-30-1955</i>			
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>m</i>	8. DATE OF BIRTH: <i>11-13-1900</i>	9. AGE last birthday: <i>55</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Md</i>	
13. FATHER'S NAME: <i>Joseph H. Collier</i>				14. MOTHER'S MAIDEN NAME: <i>Laura M. Edenfield</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <i>Mr. Devery J. Simms</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>330x Intracranial haemorrhage</i>							
ANTECEDENT CAUSE (S) (B) <i>Rupture Congenital Cerebral Aneurysm, Right int. carotid artery</i>						<i>Approx. 1 week</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>12/26/55</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Right carotid arteriogram demonstrating aneurysm neck dissection and application clamp</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/26, 1955</i> to <i>12/30, 1955</i> that I last saw the deceased alive on <i>12/30, 1955</i> , and that death occurred at <i>8:05 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>John P. Ford M.D.</i>				M. D. <i>2025 EYE ST. WASH DC</i> DATE SIGNED <i>12/30/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1/3/55</i>		NAME OF CEMETERY OR CREMATORY <i>Ht. Lincoln</i>		LOCATION (City, town, or county) (State) <i>Colman Manor, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>12/30/55</i>		REGISTRAR'S SIGNATURE <i>Amanda Downey</i>		24. FUNERAL DIRECTOR <i>John Lee & Sons</i>		ADDRESS <i>Washington DC</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 4 1956

BUREAU V. S.

12275

Items 7 8 9 File # 9182 3-1-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Prince George's</i> MARYLAND		CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Colman Manor, Ind.</i>		STATE <i>Maryland</i> COUNTY <i>Prince George's</i>		CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Colman Manor, Ind.</i>	
TOWN <i>Cherry, Ind.</i>		LENGTH OF STAY (in this place) <i>11 days</i>		STREET ADDRESS (If rural give location) <i>3407-37th Ave.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Prince George's Gen. Hosp.</i>							
3. NAME OF DECEASED: (First) <i>Lawrence</i> (Middle) <i>Sorell</i> (Last) <i>Sorell</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>Dec. 23, 1955</i>			
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>N</i>	7. SINGLE, MARRIED, WIDDED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>10/12/74</i>	9. AGE last birthday <i>81</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Wash. D.C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Wm. Austin Sorell</i>				14. MOTHER'S MAIDEN NAME: <i>Maria Jane Sorell</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Wilhelmina Sorell</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Acute Coronary Necrosis</i>							
ANTECEDENT CAUSE (S) DUE TO (B) <i>Generalized Arteriosclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9-4</i> , 19 <i>55</i> , to <i>12-23</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12-23</i> , 19 <i>55</i> , and that death occurred at <i>9:50 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>A. Dettz, M.D.</i>		ADDRESS <i>H. G. Hottel, M.D.</i>		DATE SIGNED <i>12-28-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <i>Burial</i>		DATE THEREOF: <i>12/27/55</i>		NAME OF CEMETERY OR CREMATORY: <i>Lincoln</i>		LOCATION (City, town, or county) (State): <i>Colman Manor, Ind.</i>	
DATE REC'D BY LOCAL REGISTRAR: <i>12/27/55</i>		REGISTRAR'S SIGNATURE: <i>Amanda Dourney</i>		24. FUNERAL DIRECTOR: <i>W. G. Schisler</i>		ADDRESS: <i>W. G. Schisler, W. G. Schisler, Ind.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 29 1955

BUREAU V. S.

12276 CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince Georges</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Prince Georges</u>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Cheverly</u>	LENGTH OF STAY (in this place) <u>6 days 18 hrs</u>	CITY (If outside corporate limits, write RURAL OR TOWN) <u>Upper Marlboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen. Hospital</u>	STREET ADDRESS (If rural give location) <u>Rt. # 4.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>RICHARD Thomas STALLINGS</u>		OF DEATH: <u>12</u> / <u>1</u> / <u>3</u> 19 <u>55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widower</u>	8. DATE OF BIRTH: <u>7-12-78</u>
		9. AGE last birthday: <u>77</u> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Tobacco Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Thomas Stallings</u>		14. MOTHER'S MAIDEN NAME: <u>Sally Tucker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mr. Blair Stallings</u> <u>Upper Marlboro, Maryland</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Toxemia, exhaustion</u>			
ANTECEDENT CAUSE (B) <u>Chronic hemorrhage</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Prostatectomy</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Jan 28, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Hypertrophic Prostate</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 3, 1955</u> to <u>Jan 3, 1955</u> , that I last saw the deceased alive on <u>Jan 3, 1955</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>James D. Dougherty</u> M.D.		DATE SIGNED <u>Jan 5, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/6/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Epiphany Cemetery</u>		LOCATION (City, town, or county) (State) <u>Forestville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/8/55</u>		24. FUNERAL DIRECTOR ADDRESS <u>Ritchie Bros. Upper Marlboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10/14/55

RECEIVED
DEC 9 1955
BUREAU V. S.
RICHARD
7-12-78 77
1213

12315

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince George		MARYLAND		STATE Md.		COUNTY Prince Geo.	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN West Lanham Hills				OR TOWN West Lanham Hills X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				4910-78 Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Annie ERB Stanford				Dec. 6 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White		Dec. 25-1868	86 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Washington - D. C.		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
?				?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
4/NO				4910-78 Ave Elmer F. Stanford West Lanham Hills Md.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) myocardial infarction							6 hrs
ANTECEDENT CAUSE (S): DUE TO (B) arteriosclerotic heart disease							4 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/8, 1955 , to 12/6, 1955 , that I last saw the deceased alive on 12/4, 1955 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Frederick E. Warner		7409 Varnum St		12/6/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12-9-55		Congressional Cem.		Washington D. C.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
12/6/55		Carrie Campbell		The S. H. Hines Co.		2901-14th St N.W. Washington D. C.	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

DEC 12 1955

RECEIVED

12277

12295

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Prince Geo</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Chesley</u>		LENGTH OF STAY (in this place) <u>2-0-54</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Mt Rainier</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen Hosp</u>				STREET ADDRESS (If rural, give location) <u>4517-30th Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Adde</u> <u>Amelia</u> <u>Strisser</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12-23</u> <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>7-5-1881</u>	
9. AGE last birthday: <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME: <u>John White</u>			
14. MOTHER'S MAIDEN NAME: <u>Annie Lynch</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.: <u>-</u>				17. INFORMANT & ADDRESS: <u>Alice McPherson - Mt-Rainier, Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>Immediate cause (a) <u>Acute congestive heart failure</u></p> <p>Antecedent cause(s) (b) <u>Cardiovascular renal disease</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				Interval Between Onset and Death			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John J. Maloney (Hyattsville, Md)</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>12-23-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Dec 24, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Fort Lincoln Cemetery</u>		LOCATION (City, town, or county) (State): <u>Colmar Manor, Md</u>	
DATE REC'D BY LOCAL REG. <u>12/24/55</u>		REGISTRAR'S SIGNATURE: <u>Amanda Lounney</u>		24. FUNERAL DIRECTOR: <u>A. Kasch's sons</u>		ADDRESS: <u>Hyattsville, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 28 1955

RECEIVED

12316

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12296

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 242

I. PLACE OF DEATH:

COUNTY Prince Georges

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Largo

LENGTH OF STAY (in this place)

1 month

HOSPITAL OR INSTITUTION OR STREET ADDRESS

In a wooded area

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE D.C.

COUNTY

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN Washington

STREET ADDRESS

(If rural, give location)

360 K St. S.E.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Porter

Tate

4. DATE OF DEATH

(Month)

(Day)

(Year)

12

28

1957

5. SEX:

Male

6. COLOR OR RACE:

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Widowed

8. DATE OF BIRTH:

2 Nov. 1880

9. AGE last birthday:

75 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

Retired

11. BIRTHPLACE (State or foreign country):

South Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

Sarah Harris

Washington, D.C.

17. INFORMANT & ADDRESS:

1347 Constitution Ave. N.E.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) DUE TO

Coronary atherosclerosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

Cardiovascular renal disease

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

M. D. ASSISTANT MEDICAL EXAM.

12-29-55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

12/29/55

Carrie Campbell

Hall Brothers - Washington, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

JAN 5 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince George</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Prince George</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glen Aeden Md</u>	
TOWN <u>Cheverly</u>	<u>1 hr.</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Geo. Gen. Hosp.</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Baby Girl Thompson</u>		OF DEATH: <u>Dec 18 1955</u>	
5. SEX: <u>Fe</u>	6. COLOR OR RACE: <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>18 Dec 55</u>
9. AGE last birthday: <u>1</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
		<u>Maryland</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Charles Speight</u>		<u>Ruth Thompson</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
762.5	(A) <u>Atelactasis</u>	
IMMEDIATE CAUSE	DUE TO	
ANTECEDENT CAUSE (S)	(B) <u>Pneumonia</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO	
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 18, 1955, to Dec. 18, 1955, that I last saw the deceased alive on Dec. 18, 1955, and that death occurred at 9:00 PM, from the causes and on the date stated above.

SIGNATURE <u>John W. Eubank</u>	ADDRESS <u>5301 Hawthorne St., Bethesda Md 20814</u>	DATE SIGNED <u>12/18/55</u>
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>	DATE THEREOF <u>Jan 56</u>	NAME OF CEMETERY OR CREMATORY <u>Prince Georges Gen Hosp</u>
DATE REC'D BY LOCAL REGISTRAR <u>2/16/56</u>	REGISTRAR'S SIGNATURE <u>Amanda Downey</u>	24. FUNERAL DIRECTOR <u>Henry W. Penn</u>
		ADDRESS <u>Cheverly Md</u>

MARGIN RESERVED FOR BINDING

RECEIVED

FEB 20 1956

BUREAU V. S.

12317

CERTIFICATE OF DEATH

Reg. Dist. No. 240...

1. PLACE OF DEATH: <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>P. H.</u>	MARYLAND <u>he</u>	STATE <u>md.</u>	COUNTY <u>P. H.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Baltimore</u>	LENGTH OF STAY (in this place) <u>25 yr</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>none</u>	STREET ADDRESS (If rural give location) <u>RR #1</u>		
3. NAME OF DECEASED: (First) <u>Henry</u> (Middle) <u>Allen</u> (Last) <u>TRUMAN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec 19 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>April 3 1885</u>
9. AGE last birthday <u>70</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farm</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>Am</u>		13. FATHER'S NAME: <u>Benjamin Franklin Truman</u>	
14. MOTHER'S MAIDEN NAME: <u>Mrs. Elizabeth Truman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Mr. Thomas T. Tarrant</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>myocardial infarction</u>			<u>12 h</u>
ANTECEDENT CAUSE (B) <u>atherosclerosis</u>			<u>yes</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>obesity</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>—</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>— M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>Dec 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 13</u> , 19 <u>55</u> , and that death occurred at <u>12:30 P.</u> from the causes and on the date stated above.			
SIGNATURE <u>Richard H. Dobson</u>		DATE SIGNED <u>12-19-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-22-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baden Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/22/55</u>		24. FUNERAL DIRECTOR <u>W. H. Jones</u>	
REGISTRAR'S SIGNATURE <u>L. H. Johnson</u>		ADDRESS <u>Walden Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 28 1955

RECEIVED

3 1882

14-55-22. Mr. J. E. ...
H. H. ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12318

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12299
Reg. Dist. No. 242

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>Unknown</u>		COUNTY <u>Unknown</u>	
CITY (If outside corporate limits write RURAL and give nearest town) <u>Chantilly</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Unknown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Geo. Palmer Highway & Hill Road</u>				STREET ADDRESS (If rural, give location) <u>Unknown</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Unknown</u>		(Middle) <u>John</u>		(Last) <u>Smith</u>		DATE OF DEATH: <u>Dec.</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>New born</u>	9. AGE last birthday: <u>Unknown</u>		10. IF UNDER 1 YEAR: <u>Unknown</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Unknown</u>		11. BIRTHPLACE (State or foreign country): <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Unknown</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Asphyxia</u> DUE TO <u>Unknown cause</u> Antecedent cause(s) (b) <u>Unknown cause</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Unknown</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2-7-55</u>				19b. MAJOR FINDING OF OPERATION: <u>Unknown</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/>							
SIGNATURE <u>John J. Maloney</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>12-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>12-7-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Methodist Cemetery</u>		LOCATION (City, town, or county) (State): <u>Bladensburg, Md.</u>	
DATE REC'D BY LOCAL REG. <u>12/5/55</u>		REGISTRAR'S SIGNATURE: <u>Carrie Campbell</u>		24. FUNERAL DIRECTOR: <u>J. J. Jones - Hyattsville</u>		ADDRESS: <u>Md.</u>	

RECEIVED

DEC 16 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12319

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12300
Reg. Dist.

No. 242

1. PLACE OF DEATH: COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits write RURAL and give nearest town) <u>Oron Well</u> TOWN <u>Oron Well</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosecroft Roseway</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>P. G.</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Oron Well</u> TOWN <u>Crest Hill</u> STREET ADDRESS (If rural, give location) <u>2337 Kenton Place</u>											
3. NAME OF DECEASED: (Type or Print) <u>Harry Clayton Walker</u>		4. DATE OF DEATH <u>Dec 3 1955</u>		5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>		8. DATE OF BIRTH: <u>Nov 15 1914</u>		9. AGE Last birthday: <u>41</u> yrs.		10. IF UNDER 1 YEAR: <u>3</u> Months <u>3</u> Days <u>19</u> Hours <u>55</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, and if retired) <u>Insurance</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Accounting</u>				11. BIRTHPLACE (State or foreign country): <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>John Hume Walker</u>						14. MOTHER'S MAIDEN NAME: <u>Nette Travers Lincherry</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY No.: <u>220-09-6259</u>				17. INFORMANT & ADDRESS: <u>Box 157 Maryd Baker Greenbelt, Md</u>							
18. MEDICAL CERTIFICATION															
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>975.1</u> Immediate cause (a) <u>Asphyxia</u> DUE TO Antecedent cause(s) (b) <u>Acute Carbon monoxide poisoning</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)												INTERVAL BETWEEN ONSET AND DEATH			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.															
19a. DATE OF OPERATION: <u>Dec 3 1955</u>												19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				21b. PLACE (Home, farm, factory, OF street, office bldg., etc) INJURY <u>Oron Well P.G.</u>				21c. (City or town) (County) (State) <u>Oron Well P.G. Md</u>							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Dec 3 1955 A.M.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				21f. HOW DID INJURY OCCUR? <u>Ran over from exhausted car</u>							
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>James S. F. Joyal</u> M. D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-3-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>															
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>				DATE THEREOF: <u>12/7/55</u>				NAME OF CEMETERY OR CREMATORY: <u>Arlington National</u>				LOCATION (City, town, or county) (State): <u>Arlington Va</u>			
DATE REC'D BY LOCAL REG: <u>Dec. 5 1955</u>				REGISTRAR'S SIGNATURE: <u>Carrie Campbell</u>				24. FUNERAL DIRECTOR: <u>F. Gaschi</u>				ADDRESS: <u>Box 157 Hyattsville, Md</u>			

BUREAU V. 1.

DEC 12 1955

RECEIVED

12279

CERTIFICATE OF DEATH

Reg. Dist. No. 231

12301

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince Georges</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>P. Georges</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>38 Charley</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL OR TOWN <u>Hyattsville</u>	15
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>77 Prince Georges General Hospital</u>		STREET ADDRESS (If rural give location) <u>4012 - Nicholson Street</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Estella</u>	(Middle)	(Last) <u>Warriner</u>	DATE OF DEATH: <u>12/1/1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5-30-1896</u>
9. AGE last birthday <u>59</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>?</u>		14. MOTHER'S MAIDEN NAME: <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>9</u>		<u>Statistic Card</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>			<u>6 wks</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Cholelithiasis & Cholelithemia</u>			<u>yr</u>
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Oct. 1955</u> , to <u>Dec 1, 1955</u> , that I last saw the deceased alive on <u>12/1</u> , 19 <u>55</u> and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Carroll A. Lee</u>		DATE SIGNED <u>12/2/55</u>	
M. D. <u>4314 Gallatin St. Hyattsville</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>12/5/55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/2/55</u>		REGISTRAR'S SIGNATURE <u>Manda Denny</u>	
24. FUNERAL DIRECTOR <u>J.W. Lee Sons Co - Wash., D.C.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 7 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12302

12280

CERTIFICATE OF DEATH

Reg. Dist. No. 245...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Pr. Georges</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Pr. Geo.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
25 <i>Riverdale</i>		16 day		41 <i>Laurel</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
76 <i>Beland Mem. Hosp</i>				314-4th St.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Almeda Revere Wheeler</i>				12 3 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>F</i>	<i>W.</i>	<i>married</i>	<i>4-17-21</i>	<i>34</i> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>Corn home</i>		<i>N.C.</i>		<i>USA</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Thomas Lloyd Ellinton</i>				<i>Nora Bessie Harris</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (if Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<i>If no</i>						<i>Hosp Records</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE						<i>1 yr</i>	
(A) <i>Carcinoma of Cervix</i>							
ANTECEDENT CAUSE (S):							
(B) <i>with Metastases</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<i>0</i>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov 17, 1953</i> , to <i>Dec 3, 1953</i> , that I last saw the deceased alive on <i>Dec 2, 1953</i> , and that death occurred at <i>7:40 A.M.</i> from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
<i>L W Melvin</i>		<i>Riversdale, Md</i>		<i>12-3-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Dec 5, 1955</i>		<i>Long Hill Cemetery</i>		<i>Laurel, Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>Dec 4-1955</i>		<i>Mrs Jas. Devere</i>		<i>de Witt Donaldson</i>		<i>Laurel, Md</i>	

RECEIVED
DEC 9 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12320

12303

Reg. Dist. No. 242

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince George's		MARYLAND		STATE Maryland		COUNTY Prince George's	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR		TOWN District Heights	
TOWN District Heights		2 mo		TOWN District Heights			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7619 Atwood St.				STREET ADDRESS (If rural, give location) 7619 Atwood Street			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) William Howard		(Middle) Wheeler		(Month) December		(Day) 3	
(Type or Print)				(Year) 19		55	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: March 8, 1918	
						9. AGE last birthday: 37 yrs.	
						IF UNDER 1 YEAR: Months Days	
						IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Mechanic				10b. KIND OF BUSINESS OR INDUSTRY: Automobile		11. BIRTHPLACE (State or foreign country): Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME: John D. Wheeler				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes W.W. 11				16. SOCIAL SECURITY No.: 220-26-1616		17. INFORMANT & ADDRESS: Mrs Catherine Wheeler, same address	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
976X Immediate cause (a) Hemorrhage and shock DUE TO Antecedent cause(s) (b) Gun shot wound of the head Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home		21c. (City or town) District Heights P. G.		(County) Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 12 3 55 6:45		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Shot self in the head with rifle			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE: James D. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/4/55 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. M. D.			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF: 12/7/55		NAME OF CEMETERY OR CREMATORY: Arlington Natl.		LOCATION (City, town, or county) Arlington Va	
DATE REC'D BY LOCAL REG. Dec. 5-1955		REGISTRAR'S SIGNATURE: Carrie Campbell		24. FUNERAL DIRECTOR: W.W. Chambers Co.		ADDRESS: 517 11 th St S E	

RECEIVED

DEC 6 1955

BUREAU V. S.

12281

12004

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 231

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince Geo Co</i>	CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Chenoweth</i>	STATE <i>Md.</i>	COUNTY <i>P. Geo.</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Prince Geo Co. Hosp.</i>		CITY (If outside corporate limits write RURAL and give nearest town) <i>Bowie</i>	
3. NAME OF DECEASED: (Type or Print) <i>Charlie J. Williams</i>		4. DATE OF DEATH <i>12 3 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>Married</i>	8. DATE OF BIRTH: <i>12 25 1903</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <i>52</i> yrs.
13. FATHER'S NAME: <i>Wilhel Williams</i>		14. MOTHER'S MAIDEN NAME: <i>Bethie ?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <i>Clara Williams Wife. Bowie Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Cerebral compression & contusion</i>	
Antecedent cause(s) (b) <i>Bilateral subdural hygromata</i>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <i>Automobile accident</i>	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
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19a. DATE OF OPERATION: <i>12-24-55</i>	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY) <i>Street</i>	21c. (City or town) <i>Bowie</i> (County) <i>P. Geo.</i> (State) <i>Md</i>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>11-24-55 P.M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>passenger in auto. in collision with truck-trailer</i>

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE *John J. Maloney (Hyattsville Md.)* M. D. ASSISTANT MEDICAL EXAM. *12-3-55*

23. BURIAL, CREMATION, REMOVAL (Specify): *Removal* DATE THEREOF *12/3/55* NAME OF CEMETERY OR CREMATORY *Hall Brother Funeral Home* LOCATION (City, town or county) *Washington* (State) *D.C.*

DATE REC'D BY LOCAL REG. *12/3/55* REGISTRAR'S SIGNATURE *Monanda Dourney* 24. FUNERAL DIRECTOR *F. Gascho Sone, Hyattsville, Md* ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 7 1965

RECEIVED

12321

CERTIFICATE OF DEATH

Reg. Dist. No. 231

Item 2, Film G191 1-11-56 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>PRINCE GEORGE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>P. GEO.</u>
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL, and give nearest town)	
<u>TOWN</u> <u>CHapel OAKS</u>	<u>11 YEARS</u>	<u>TOWN</u> <u>Chapel Oaks</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
		<u>5421 Nash St., N. E.</u>	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>MARY</u>	(Middle) <u>M. WILLIAMS</u>	(Month) <u>12</u>	(Day) <u>28</u>
(Type or Print)		(Year) <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>JAN-17-1883</u>
		9. AGE last birthday: <u>72</u> yrs.	10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>NONE</u>	
11. BIRTHPLACE (State or foreign country): <u>ST. MARYS COUNTY, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>RICHARD BROWN</u>		14. MOTHER'S MAIDEN NAME: <u>SOPHIA ARMSTRONG</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes; no, or unk.) (If Yes, give war or dates of service) <u>#NO</u>		16. SOCIAL SECURITY No.: <u></u>	
		17. INFORMANT & ADDRESS: <u>MRS. MATILDA EPPS</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Congestive Heart Failure</u>		
Antecedent causes (s) (b) <u>Hypertensive Cardio-Vascular Disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Senility</u>		

11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY ?
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input type="checkbox"/>
19a. DATE OF OPERATION: <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 1950, to Dec. 28, 1955, that I last saw the deceased alive on Dec. 26, 1955, and that death occurred at 1001 Eastern Ave, from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town or county)	DATE SIGNED
<u>BURIAL</u>		<u>12/31/55</u>	<u>St. Olivet</u>	<u>Washington D.C.</u>	<u>12/28/55</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS	
<u>12/28/55</u>	<u>Amanda Lounney</u>	<u>John I. R. Hines & Co.</u>		<u>901-3rd St. S.W.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 2 1936

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12322

12306
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Glen Dale</u>		<u>transient</u>		TOWN <u>Mitchellville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Office of Dr. Hurty</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Allen Wilson</u>				<u>12-24 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Oct-10-1955</u>	9. AGE last birthday: <u>2 1/2</u> years	10. IF UNDER 1 YEAR: Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Robert Wilson</u>				14. MOTHER'S MAIDEN NAME: <u>Sadie Fitzgerald</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mother - Same address</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Exhaustion</u>							
DUE TO							
Antecedent cause(s) (b) <u>Malnutrition</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>24</u>							20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
19b. MAJOR FINDING OF OPERATION:							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John J. Maloney (Hyattsville Md)</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-24-55</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF: <u>12-25-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Chapel</u>		LOCATION (City, town, or county) (State): <u>Owensville, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 24, 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. Lewis H. Giegling</u>		24. FUNERAL DIRECTOR <u>William Reese</u>		ADDRESS <u>-108 Wash. St., Annapolis, Md</u>	

210535V344

RECEIVED

JAN 2 1966

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12323

CERTIFICATE OF DEATH

Reg. Dist. No. 232

12307

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Pr. Geo's.</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Pr. Geo's.</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>X</u> TOWN <u>Melwood</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Melwood</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt.#4.</u>		STREET ADDRESS (If rural give location) <u>Rt.#4</u> <u>/</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) (Middle) (Last) <u>John</u> <u>Henry</u> <u>Windsor</u>		<u>12</u> <u>9</u> <u>19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>June 11, 1891</u>
9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>64</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Maintenance Man</u>		<u>State Roads Comm.</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Dick Windsor</u>		<u>Martha Talbott</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>Unk.</u>			
17. INFORMANT & ADDRESS:			
<u>Alfred E. Windsor</u>		<u>Upper Marlboro, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Acute Congestive heart failure</u>			
ANTECEDENT CAUSE (B) <u>Cardiovascular renal disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>260 X</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Alcoholic Intoxication</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 9, 1955</u> to <u>Dec 9, 1955</u> , that I last saw the deceased alive on <u>Dec 9, 1955</u> , and that death occurred at <u>1:30 P.</u> M., from the causes and on the date stated above.			
SIGNATURE <u>James D. Boyd</u>		ADDRESS <u>Forest Hill Rd. 12-11-55</u>	
M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>12/12/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>St. Thomas Cemetery</u>		<u>Croom Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>Dec 12 1955</u>		<u>Ritchie Bros. Upper Marlboro, Md.</u>	
REGISTRAR'S SIGNATURE <u>John F. Danner</u>			

BUREAU V. S.

DEC 14 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12324

CERTIFICATE OF DEATH

Reg. Dist. No. 12308 243

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Pr. Geo's.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Pr. Geo's.</u>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
X TOWN <u>Mitchellville</u>	<u>55 yrs.</u>	TOWN <u>Mitchellville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>Mattie</u> --- <u>Wood</u>		OF DEATH: <u>12</u> <u>22</u> 19 <u>55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>June 28, 1875</u>
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>80</u> yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Hswf</u>		<u>Own Home</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Washington, D. C.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Dennis Deakins</u>		<u>Annie E. Steele</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>			
17. INFORMANT & ADDRESS:			
<u>Gladys Marie Gray</u>		<u>106 54th Place, Maryland Park, Md.</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE		<u>2 hrs.</u>	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Cerebral Hemorrhage</u>			
DUE TO			
(B) <u>Hypertensive Cardio-</u>			
DUE TO			
(C) <u>Vascular Brain Disease</u>		<u>10 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>15 yrs.</u>	
<u>Arteriosclerosis</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>None</u>		<u>—</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
<u>None</u>		<u>None</u>	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<u>None</u>		<u>None</u>	
22. I hereby certify that I attended the deceased from <u>June 1, 1955</u> to <u>Dec. 22, 55</u> , that I last saw the deceased alive on <u>Dec 22, 1955</u> , and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>James L. Sasser</u>		<u>Upper Marlboro, Md 12-22-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>12/24/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Mt. Oak Cemetery</u>		<u>Mitchellville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>12-27-55</u>		<u>Mrs. Agnes W. Grogan</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Ritchie Bros.</u>		<u>Upper Marlboro, Md.</u>	

BUREAU V. S.

JAN 2 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12282

CERTIFICATE OF DEATH

Reg. Dist. No. 12309

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Prince George</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cheeverly -</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Upper Marlboro -</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Geo. Gen. Hosp.</u>		STREET ADDRESS (If rural give location) <u>Route 1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>Nellie</u> <u>V</u> <u>Wood</u>		<u>Dec</u> <u>19</u> <u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>Female</u>	<u>white</u>	<u>widowed</u>	<u>July 20, 1888</u>
9. AGE last birthday <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joshua Elisha Ferguson</u>		14. MOTHER'S MAIDEN NAME: <u>Victoria Richardson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>John H. Wood, Son, RFD #1 Clinton, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Uremia</u>		<u>3 weeks</u>	
ANTECEDENT CAUSE (B) <u>Nephrocalcinosis bilateral</u>		<u>6 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Chronic Pyelonephritis</u>		<u>8 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>12/3/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Bilateral Renal calculi</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/2/55</u> , 19... to <u>12/19/55</u> , 19..., that I last saw the deceased alive on <u>12/19/55</u> , 19..., and that death occurred at <u>2</u> AM, from the causes and on the date stated above.			
SIGNATURE <u>Sam R. Luskaty</u>		DATE SIGNED <u>12/19/55</u>	
M. D. <u>mt. Rainier, Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>12-21-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Christ Church Cem</u>		LOCATION (City, town, or county) (State) <u>Clinton, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/20/55</u>		REGISTRAR'S SIGNATURE <u>Amanda Downey</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers & Co</u>		ADDRESS <u>Washington, D.C.</u>	

RECEIVED

JEC 22 1955

BUREAU V. 31

12221

CERTIFICATE OF DEATH

Reg. Dist. No. 244

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Prince Georges		MARYLAND		STATE Maryland		COUNTY Pr. Geo.	
CITY (If outside corporate limits, write OR and give nearest town) 16 Mt. Rainier		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write OR and give nearest town) 16 Mt. Rainier			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 2405 ARUNDEL RD				STREET ADDRESS (If rural give location) 1 2405 Arundel St.			
3. NAME OF DECEASED: (First) THOMAS.		(Middle) W.		(Last) WRIGHT SR		4. DATE OF DEATH: (Month) DEC. (Day) 19 (Year) 55	
5. SEX: MALE	5. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: SEPT. 21, 1891	9. AGE last birthday: 64 yrs.	10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: STOCK CLERK		
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: STOCK CLERK				10b. KIND OF BUSINESS OR INDUSTRY: WASH. REFRIGERATION CO		11. BIRTHPLACE (State or foreign country): CHARLES CO. MD.	
13. FATHER'S NAME: THOMAS W. WRIGHT				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES				14. MOTHER'S MAIDEN NAME: EDNA JANE MILLSTEAD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES		16. SOCIAL SECURITY No.: W.W. #1 220-01-0865		17. INFORMANT & ADDRESS: THOMAS W. WRIGHT JR. 1204 DALEWOOD DR. SILVER SPRING MD.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
420.1 Immediate cause (a) Acute myocardial Infarction		2 hours
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Coronary Artery Disease		1+ years
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: 0		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 19, 1955, to Dec. 19, 1955, that I last saw the deceased alive on Dec. 19, 1955, and that death occurred at 3:30 AM from the causes and on the date stated above.

SIGNATURE Arnold J. Dean		ADDRESS 4314 Gallatin St. Hyattsville, Md		DATE SIGNED 12/19/55	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE THEREOF 12-22-55	NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL CEMETERY	LOCATION (City, town, or county) Prince Georges Co. Md.	(State)	
DATE REC'D BY LOCAL REGISTRAR Dec 19/55	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR [Signature]		ADDRESS [Address]	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 21 1955

BUREAU V. S.

12283

CERTIFICATE OF DEATH

Reg. Dist. No. 272.

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Prince Georges	MARYLAND	STATE Md.	COUNTY Prince Georges
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cliverly	LENGTH OF STAY (in this place) 6 mo-55 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Clinton	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince Georges Hospital		STREET ADDRESS (If rural give location) Rt 1. Box 120	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) Blanche Young.		4. DATE (Month) (Day) (Year) OF DEATH: 12-11-1955	
5. SEX: F	6. COLOR OR RACE: Col	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) (m)	8. DATE OF BIRTH: 3-18-89
9. AGE last birthday 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: unk.		14. MOTHER'S MAIDEN NAME: unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: Hospital Record			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 260X		1 met	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		2 Days	
		10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		1 Day	
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 11, 1955, to Dec 11, 1955, that I last saw the deceased alive on Dec 11, 1955, and that death occurred at 5:10 P.M. from the causes and on the date stated above.			
SIGNATURE Samuel M. Sugar		DATE SIGNED 12/12/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		NAME OF CEMETERY OR CREMATORY Clinton Cem.	
DATE THEREOF 12-14-55		LOCATION (City, town, or county) Clinton Pr. Geo Md	
DATE REC'D BY LOCAL REGISTRAR Dec. 13-55		REGISTRAR'S SIGNATURE Carrie Campbell	
24. FUNERAL DIRECTOR		ADDRESS	
Mable K. Rallin		4339 Huntcl. N.E.	

BUREAU V. S.

DEC 19 1955

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